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Limitations of reason and liberation of absurdity: reason and absurdity as means of personal and social change

Stephen Brigham
University of Wollongong

LIMITATIONS OF REASON AND LIBERATION OF ABSURDITY:
Reason and Absurdity as Means of Personal and Social Change.
Case Study: Psychotherapy

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STEPHEN BRIGHAM, BA (Hons)

SCIENCE, TECHNOLOGY & SOCIETY
SCHOOL OF SOCIAL SCIENCES, MEDIA AND COMMUNICATION
FACULTY OF ARTS

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CERTIFICATION

I, Stephen Brigham, declare that this thesis, submitted in fulfilment of the requirements for the award of Doctor of Philosophy, in the School of Social Sciences, Media and Communication, University of Wollongong, is wholly my own work unless otherwise referenced or acknowledged. The document has not been submitted for qualifications at any other academic institution.

Stephen Brigham

8 June 2005

ACKNOWLEDGEMENTS

The journey of this dissertation commenced too many years ago. I have been a busy professional, first with the public health system and later as a private practitioner and academic, and struggled to fit my doctoral research into this. Though I envy those who can put aside three years of their life to focus on a PhD, my journey had to be different as it grew out of my clinical practice and philosophical ponderings. I am deeply indebted to my wonderful PhD supervisors, Brian Martin and Don Mixon, who are excellent, stimulating and unrestrained minds and, given the prolonged incubation, patient and optimistic souls.

Then of course there are the many clients and colleagues I have worked with over the last 30 years of professional practice. In this thesis I have presented stories of encounters with people that may be interesting and amusing to the reader, but for me are memories of how we grapple with problems and suffering, can be courageous, and how we can all be revolutionaries.

My family were so relieved when finally I could tell them that I had finished the damn thing. It has been a long journey with the PhD lurking in the background. There were times when I could have pulled the plug, especially when I was busy with work and felt I wasn't able to commit the time to my research. My dear wife Kate never faltered in her support and was my provocative therapist when I muttered about not needing a PhD. Well, the damn thing is finished, thanks to them.

Abstract

Reason and absurdity are two processes for bringing about personal change, with very different implications for power and control in interpersonal relationships focussed on change. I approach the topic of reason and absurdity as change processes in two ways. The first is through a conceptual discussion of reason and absurdity. My main argument is that reason is limited in the degree or type of change it can lead to whereas absurdity is better placed to lead to profound change. I also make the case that reason is normally based on persuasion, power and control whereas absurdity is a means of turning dominant paradigms and power inequities on their heads. My second approach is to use psychotherapy as a case study of personal change by first providing an overview of psychotherapy as a serious activity based on reason and then discussing ways in which absurdity, particularly as humour and paradox, can be an effective form of psychotherapy. I give many examples and case vignettes of these to demonstrate the potential of absurdity for fostering profound personal change.

Since its inception in the late 19th century, modern psychotherapy has sat firmly within the science-reason paradigm. Exponents of the major psychotherapeutic orthodoxies — psychoanalysis, behaviourism, cognitive-behaviourism, and even humanistic psychology — have mostly couched their descriptions and guidelines in the language of science and rationality. Before the 1970s there was little reference in the professional literature to therapeutic humour and paradox and though interest in them has steadily increased since then it is still minimal whereas trivialisation and suspicion are common. Contemporary psychotherapeutic orthodoxy now also demands evidence-based practice; replicable, easy to teach techniques and outcomes; and accountability, with academic, professional and financial support now mostly dependent on these criteria.

In contrast, since the 1970s there has been a proliferation of psychotherapies into the several hundreds. Many of these developed in reaction to a perception that reason-based talking therapy was limited. New themes became increasingly represented through concepts of human potential, liberation, spontaneity, self-actualisation, Eastern philosophies and spirituality. A new wave of therapies reflected alternative beliefs and practices to the dominant science-reason

paradigm and emphasised direct experience and profound change rather than talking about experience and change as adaptation to social expectations.

Where a person goes to therapy to make specific changes to behavioural or cognitive patterns, linear, reason-based, cognitive-behavioural techniques can be very effective. On the other hand, to produce profound or complex change, absurdity may be a better approach, bypassing habitual cognitive patterns, seeing the comic in the tragic, shocking the person into dramatically new ways of behaving and thinking. If this is so, absurdity should be seen as at least equal to reason and, in some cases, superior.

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CHAPTER 1: WHY THIS TOPIC

OVERVIEW OF THE THESIS

The topic of this thesis is reason and absurdity as processes towards personal change using psychotherapy as the major case study to explore this. Essentially it is in two parts with the intention that ideas in the first part maintain a presence during the reading of the second part. The first part is a conceptual discussion of reason and absurdity as means to change and relates to the hypotheses outlined in this chapter. It presents the argument that reason typically leads, perhaps can only lead, to simple change whereas absurdity is better placed to lead to profound change. It also addresses implications of reason and absurdity as influences on power and control in interpersonal relations. The second part is about psychotherapy. It provides an overview of psychotherapy, a discussion of how and why psychotherapy has been grounded in the assumptions of science and reason, and a comprehensive presentation of psychotherapy as absurdity.

INTRODUCTION TO THE TOPIC

The focus of this thesis is on reason and absurdity, mostly the latter, and within this there are two underlying themes of 'change' and 'paradigms'. The thesis examines the types, degrees or levels of change that can arise from reason and from absurdity, including how able each is to bring about profound change. The approach to change focused on is psychotherapy. Profound change through psychotherapy can involve major shifts in how a person experiences their world, represents it through thought, and responds to it emotionally and behaviourally. Profound personal change, in contrast to change as adjustment or adaptation, is transformative, a change to the nature of something rather than simply an aspect of it, perhaps even transcendental, going beyond or surpassing what one was. Of course the reasons, and degree of change, for which people have psychotherapy are many and varied. Some are seeking minimal change for which simple therapeutic input will be sufficient. These are occasions where linear, reason-based, cognitive-behavioural techniques can be very effective. For others, struggling with

severe or chronic problems, or aspiring after profound personal growth, the means to change may have to be more complex, engaging aspects of the person beyond their reasoning, and bringing about experiences outside what they had previously considered typical and normal.

My original intention, as described below, was to look at reason and absurdity as means to both personal and social change, using organisational change and green political activism as well as psychotherapy as my case studies, but it became evident that this would be too grand a venture to be undertaken in a single thesis. The reason for wanting to include the other two case studies was to take my discussion beyond the personal into the social, shared, realm of paradigms. With the focus now on personal change considerations of paradigm change are implied rather than explicitly discussed. Some brief comments about the concept of 'paradigm' are therefore appropriate.

The concept of 'paradigm' relevant here is the more general use referring to a socially shared world-view rather than the more limited Kuhnian reference to scientific models (Kuhn, 1970). Since the 1960s there has been increasing discussion about a 'new paradigm', 'alternative paradigm', or 'wholistic paradigm' held in contrast to what is referred to as the 'old paradigm', 'conventional paradigm' or 'dominant paradigm'. The mechanistic and reductionist conventional paradigm is the methodological basis for science and the orthodoxy by which any analysis of the world, including analysis of people, is judged. It has a long history, being taught at universities in the 14th century and entrenched as scientific methodology by the 17th century by the likes of Galileo, Kepler and Descartes (Mathews, 1991, p. 15). It depicts a single reality made up of separate entities interacting according to sets of laws that can be discovered and understood through the mechanistic, reductionist methodology known as science.

As a socially shared and reinforced world-view, the conventional paradigm constitutes what we believe reality to be and determines what means we should use in trying to understand and explain it. World-view and methodology have to be consistent. The mechanistic reductionist world-view has generated a mechanistic and reductionist methodology through which we can further observe and describe the universe in mechanistic and reductionist terms. The

conventional, dominant paradigm is maintained through scientific enquiry based on application of reasoning and logical thinking.

The dominance of the science-reason paradigm provides us with our 'common sense' belief in a single objective reality. There are advantages in seeing the world this way but huge dangers in believing this is the only way to see the world, that the science-reason model is the 'truth' and all other ways are false, illusion, or insane. The world's massive environmental problems resulting from human activities based on the dominant paradigm bear witness to this and yet alternative models and approaches still mostly fall on deaf ears of the elites that could make a difference.

Dominance of one belief system or world-view, as with dominance of any single power, is likely to lead to oppression by orthodoxy over anything considered inferior or heretical. This may be performed quite innocently, not out of a drive for power but simply the conviction that "this is the best way". Humanity thereby becomes deprived of alternative views or paradigms, unusual methods and 'uncommon senses', minority cultures and rare species. These processes lead to standardisation, sameness, blandness, mediocrity and the perhaps illusory belief in predictability. As will be seen in the next chapter, this is the point, and the limitation, of reason. Part of the definition of reason is that reason is the basis for sound judgement, sensible conduct and sanity which in practice means not thinking or behaving outside the limits pre-set or implied by reason and not being greatly less or more than might be expected. This definition is detailed in the next chapter.

From the perspectives of reason and science, many of the claims and practices of alternative paradigm approaches to change appear to be, or are claimed to be, illogical, irrational, unreasonable and thereby, by implication at least, invalid and perhaps "lunatic" and dangerous. The assumption is that reason and, by association, science provide the superior or only worthwhile explanations of how things are and why people are the way they are. The reason-science dominant or conventional paradigm is the orthodoxy by which the world is to be understood, the presupposition by which the validity and status of theory and practice is judged and given credibility or not, not only within the scientific community but also in the public eye. Status and credibility bring with them funding and the momentum of training, and thereby

dominance over theories and practices judged to fall outside the orthodoxy. Consequently the vast bulk of university clinical psychology training in Australia is based on cognitive behaviour therapy (CBT) and university research into therapeutic modalities is focused on comparing CBT with non-psychological forms of treatment such as medication. Here and there are a few remnants of previous orthodoxies, notably psychodynamic approaches to therapy such as Interpersonal Psychotherapy and Brief Psychodynamic Therapies. Similarly, it seems unlikely that environmental science departments will offer ecophilosophies as a component of their degrees, preferring to play safe and perpetuate conventional practices in environment management and resource use. The same theme can be found in medical training where students interested in alternative medicine will usually have to attend private institutions or, at best, where some alternative approaches are taught in universities they are colonised by orthodox medicine often incurring a reframing of their underlying rationale or philosophy. An example of this is acupuncture, an ancient treatment based on the principle of life-force ('chi' or 'ki') flowing through invisible channels ('meridians'), that is slowly gaining some acceptance in orthodox medicine but only by seeking explanations based on its own assumptions, renamed 'medical acupuncture', and preferably practised only by medical practitioners, to differentiate it from what are then seen as invalid activities of non-medical 'charlatans'.

These are examples of the institutionalised dominant reason-science paradigm either banishing or swallowing alternative paradigm theories and practices. One of the arguments I shall employ is that dominance is about power, and reason is the tool most used to establish that power. Reason thereby tends to perpetuate itself, its assumptions, and its institutions, ensuring that any change that does occur will be gradual, evolutionary not revolutionary, and consistent with the assumptions on which it is built. Absurdity poses a threat to this conservative self-perpetuation.

It needs to be noted here that I often refer to reason, science and absurdity in a reified or personalised manner as a way of depicting how people work with, and are influenced by, reason, science or absurdity. An example of this is when I refer to reason masquerading as absurdity and state that "perhaps such a masquerade reveals reason's envy or fear of the potential power of absurdity." I am using this as a literary device, not as a portrayal of them existing as anything other than activities performed by people. Reason, science and absurdity

are activities of great complexity involving many interactions and influences, and possible interpretations of their meaning and impact. I have endeavoured to present the range of possible relations and interactions between reason and absurdity but I acknowledge that my use of reification has the potential to pit them against each other implying an antithetical and possibly even, at times, antagonistic relationship, as reflected in the stronger versions of my hypotheses below.

In my case study of psychotherapy, I provide numerous examples in which the relationality of reason and absurdity is evident but with the introduction of absurdity the therapeutic process is taken beyond where it could have gone with the use of reason alone. Their relationality is murkier when they are viewed as bases for paradigms through which to interpret the world and the question of whether absurdity reflects a fundamentally different paradigm or a modification to the dominant reason-science paradigm.

TWO 'HYPOTHESES' AND A 'GOAL'

A hypothesis is a proposition attempting a tentative explanation of an event the validity of which, it is believed, can be ascertained through data arrived at through scientific methodology. It is a proposed prediction of the results of empirical testing of relationships between constructs seen as variables. These relationships may be believed to be ones of cause-effect or, if not, there is still some correlation between their occurrence. How hypotheses are arrived at varies considerably. A naïve view of science would assume hypotheses arise from detailed observation and methodical thinking but in reality many are little more than assumption or guesswork. Of relevance here is the fact that hypotheses can also arise from nonrational, non-methodical, creative and absurd processes, intuition, freewheeling imagination and sudden flashes of inspiration.

Initially I developed two working hypotheses as backdrops for this thesis but as my investigation progressed each bifurcated into a stronger and softer version. After trying to create blends, I decided it would be more interesting to present each hypothesis as two options to

consider. The differences are not huge but they are relevant. The hypotheses are concerned with modern cultures, not traditional cultures. Although the hypotheses could probably be made amenable to empirical testing, it has not been my aim to conduct such testing myself, at least not for the purposes of this thesis. My aim from the outset was to explore constructs rather than conduct an exercise in scientific methodology as the latter would have been inappropriate given my critique of the reason-science paradigm that underlies this thesis.

Hypothesis #1

Softer version: Change stemming from or brought about through reason is likely to be limited in extent or depth. Reason cannot easily lead directly to change outside the dominant science-reason paradigm. Absurdity, on the other hand, contradicts 'common sense' and preconceived notions and has the potential to lead to profound change beyond the dominant science-reason paradigm.

Stronger version: Change stemming from or brought about through reason will, by definition, be limited in its extent, depth, or nature. Reason cannot lead directly to change outside the dominant, defining, science-reason paradigm. Absurdity, on the other hand, contradicts 'common sense' and preconceived notions and has good prospects of leading to profound change beyond the dominant, science-reason paradigm.

Hypothesis #2

Softer version: Compared to absurdity, reason more readily lends itself to serving power relationships based on inequity and manipulation. Although absurdity can be used in the service of power and control, it more readily lends itself to undermining power relationships.

Stronger version: Reason readily lends itself to the service of control involving power relationships based on inequity permitting it to be used systematically in interpersonal interactions, and more broadly in society, as manipulation. Reason, in the service of control, is a method of manipulation that perpetuates and creates inequality. The power of absurdity works

differently. Although absurdity can appear to be used in the service of power and control, these are cases of reason masquerading as absurdity. Absurdity undermines power relationships.

This second hypothesis is about power and control, indicating that total reliance on reason can ultimately lead to its use as persuasion to force agreement or compliance with the more powerful (in reason's own terms) argument, ending in a win-lose conclusion. Reason then becomes a means to gain control. In this light, reason, power, persuasion, coercion and force are all means to bring about one end, which is control. Reason might not be inevitably a means to control but, by definition, as outlined in Chapter 2, it readily becomes one. Given this, the term "science-reason paradigm" could be replaced with "science-control paradigm".

It may be that all human interactions involve power, and thereby control, in some way, and it is not only reason that leads to this. Absurdity can also be used to perpetuate or establish power inequity, such as through some forms of humour and when paradoxical interventions are used as manipulation in therapy - raising the question of whether these are genuine examples of absurdity or of reason masquerading as absurdity. Irrespective of this, absurdity has the potential to turn dominant arguments and power inequities on their head. Where power inequities are maintained through reason, absurdity may be the antithesis and source of liberation, at least psychologically.

An Associated Goal

In researching for and writing this thesis I have a goal, associated with the two hypotheses, to provide an informative contribution to the literature on absurdity as a change process, particularly as a means to personal change through psychotherapy. As well as providing discussion on reason and absurdity as change processes, I am offering a detailed presentation on why absurdity has been given so little attention in psychotherapy and ways in which it can be applied in the practice of psychotherapy. The goal is to place absurdity firmly in the psychotherapy debate and in so doing introduce interested practitioners to ways to bring absurdity into their sessions and relationships with clients.

PERSONAL REASONS FOR CHOOSING THIS TOPIC

This thesis has emerged from activities, interests and passions that have been significant and defining aspects of my life for a long time. Of these there are three that particularly stand out as leading me to an interest in absurdity as a stimulant for profound change.

After leaving school at the age of sixteen and working for a couple of years to save money, I spent seven years travelling around Europe, Asia and Australasia before returning to England to study for my degree. After completing Honours I then spent another couple of years in India before eventually settling first in New Zealand and finally in Australia. My experiences as a traveller had profound effects on my approach to life and philosophical outlook, especially as my geographical travelling also became partly a spiritual journey. A lot of my travelling was in Asia, mostly India where I spent two and a half years, much of which time I spent living in Tibetan refugee communities, and some months in Sri Lanka spent in a meditation retreat at a Buddhist forest monastery.

During my undergraduate years in England in the late 1970s I became passionate about environmental issues and founded one of Britain's most influential student environmental activist groups. I have since spent many years being an environmental activist fuelled by a desire for radical socio-political change as means to bring about the extent of change I believed essential to solve what I saw to be almost intractable problems. During the late 1980s and early 1990s I was a key player in creating the Australian Greens, the green political party in Australia. I was their New South Wales number one Senate candidate in 1993 and I continue to be actively involved. One issue that has particularly intrigued me is how a grassroots consensus-based non-violent movement can become effective in an adversarial elitist political system.

I graduated in 1980 with an Honours degree consisting primarily of psychology and philosophy. Since 1982 I have worked both in public health and private practice as a registered psychologist and psychotherapist, and since 1990 also as an academic, initially casual and now tenured. I consider my professional role to have been one principally working with change, mostly as a

psychotherapist and psychologist but also as a consultant and trainer with community groups, government departments and commercial organisations. Previous to my psychology degree, in the mid-1970s, I undertook psychiatric nurse training at a labyrinthian psychiatric hospital steeped in archaic attitudes and oppressive practices about how to manage the 'mentally ill'. One thing that impressed me was how often patients' absurdity could serve them well and how this contrasted with the usual overbearing grimness of most of the staff. I came across the use of absurdity in therapy early in my professional career, particularly through the work of Milton Erickson and Frank Farrelly, and it has become a significant component of my approach. I now run a training workshop for therapists and counsellors entitled: *Therapy Through Humour & Absurdity: Liberating Clients & Therapists From the Tyranny of Grimness*.

BACKGROUND TO THE TOPIC

As is often the case with PhDs, my topic underwent some transformation during the initial planning and exploratory period. The original intention was to focus much more on the current and potential roles of 'alternative paradigms' and transpersonal and ecology-inspired philosophies in personal and social change. Reflecting my primary interests and activities, personal change was to be studied via the case example of psychotherapy and social change via green political activism. My initial outline included the following.

'Ecophilosophies', such as deep ecology, social ecology, ecofeminism, 'Gaia', are presented by their exponents not only as analyses of the world and our ways of relating and constructing the world but also as potential practical models with which to change society and human relationships. Other 'new paradigm' models have similarly been offered, and to varying degrees incorporated into social and psychological practice, over recent decades - particularly since the development of humanistic psychology in the 1960s. Notable among these are existentialism, eastern spiritual philosophies such as buddhism and taoism, and indigenous people's traditional knowledge - especially North and South American native peoples. A significant common characteristic of all these philosophies, and the prescribed behaviours and practices stemming from them, is a concept of self that in some way can transcend the everyday egoistic sense of self and subject-object dichotomies imbibing a sense of 'oneness' with nature, the universe, or a spiritual essence such as 'God'. This transcendent state is depicted as a somehow 'higher' state of being, variously referred to in terms such as 'self-actualisation', 'authenticity', 'nirvana', 'ecological self', 'ecological-consciousness'.

I am interested in how these philosophies and concepts of selflessness can be translated into practice. In some cases, means to achieve this have already been developed, particularly in psychotherapy and 'consciousness-raising' techniques, and I am interested in assessing how this has been developed, how they are experienced by participants and what the underlying assumptions might be. Of considerable interest in this part of the study is to look at how the 'new paradigm' views and behaviours could exist alongside established views and behaviours. How have humanistic and transpersonal psychology, and alternative healing models, been set up against or alongside existing, orthodox, mechanistic structures and belief systems. How do the new approaches 'sit with' the orthodoxies and how can the concepts of the new approaches be developed as practice and structures? It will be interesting to see how much the experiences in psychology and health may be relevant and useful to the endeavour to translate 'ecophilosophical' ideas into societal and personal change.

The first adjustment to the topic arose from the realisation that simply to divide approaches to change into 'conventional paradigm' and 'alternative paradigm' was too general and impractical when trying to apply to the 'real life' case examples. To overcome this I needed to settle on specific behaviours, types of behaviours or reasonably definable concepts underlying behaviours.

The conventional or dominant paradigm underlying psychology and most models of psychotherapy has long been that of science and reason with the accompanying insistence on standardised techniques and measurable outcomes that have become increasingly rigidified by the demands of economic rationalism and accountability. My study had to focus on a contrasting mode to reason that could be associated to some degree with assumptions and values of the 'alternative' or 'wholistic' paradigms through which fundamental change was seen to involve the person going beyond reason and linear cognitive processing.

An obvious contrast, perhaps polarity, to reason is absurdity. Dictionary definitions of absurdity include 'contrary to reason or common sense' (Macquarie) and 'incongruous', 'unreasonable' (Oxford). In psychotherapy absurdity can appear in numerous forms, as described later in this thesis, such as humorous interventions, paradoxical strategies, playing devil's advocate, ironic provocation, creating cartoons or composing songs about clients' problems. In green political activism it most commonly occurs as 'way out' direct actions, some forms of street theatre,

burlesque, caricaturing, political satire, paradoxical actions. An example of the latter was a group of Norwegian anti-war activists campaigning to have people freed from prison who had been sent there for resisting conscription. Part of their agenda was also to attract media attention to publicise this policy of imprisoning war resisters, a policy they described as "state violence".

> We decided to plan for a "jail-in" action. Our friends sat in prison as a result of their attitudes against the state: we had the same attitudes. What would be more just than us sitting in the same place? With ladders and ropes we climbed over the walls and demanded either to let all war resisters be free or imprison all of us! The guards looked very surprised when one after another of us jumped down on the inside of the prison and demanded to be imprisoned! The alarm bells rang, dogs and police arrived, the prisoners encouraged us with shouts and songs, the guards scratched their heads and we had a good time.
>
> After hours of discussion with the director of the prison, a press conference with one of the war resisters and heavy media coverage all over the country, we were arrested when we went out of the gates of the prison. To be carried from the outside in is not that uncommon, but police carrying activists out of the prison once more brought smiles to thousands of people.
>
> We were charged over the action. The case was dismissed after one year of investigation. The reason is quite obvious: What could the judge threaten us with? Imprisonment? (Johansen, 1991, p. 28)

I felt that psychotherapy and green political activism could be used as case studies to explore reason and absurdity as contrasting approaches to change and reflections of different paradigms. They are both explicitly about trying to change established patterns and structures of human behaviour. They are both represented by practitioners from a wide range of philosophical positions and ways of influencing change. They both involve considerable debate and disagreement about the roles of science, experts, logical argument, appealing to reason, emotion, intuition, and the use of 'pantomime' and 'irrational' or 'nonrational' interventions. Though mostly preoccupied with attempts to be true to science and reason, within both exists a wealth of approaches to change variously described as absurd, paradoxical, crazy, humorous, unreasonable, irrational, nonsensical, unscientific (even anti-science), unusual, unconventional, outrageous or radical.

Though there are obviously many differences in context, activities and goals between psychotherapy and green political activism, I was able to identify a number of similarities between them.

- Both are to do with suffering, conflict, self-defeating or destructive behaviour, and alienation (from self, from others, from nature). They have explicit goals to change human activities and perceptions from ones which are seen as problematic, causing damage and sickness to ones believed to remove or solve problems, repair or reverse damage, treat sickness and malfunction and restore healthy functioning.
- The problems they focus on often involve entrenched, long term patterns of behaviour maintained by social institutions, attitudes and beliefs, self-interest and often power biases.
- They are seen as attempting to facilitate change in the behaviour and thinking of people but they often have to deal with people who may not recognise a need to change or, even if they do, become resistant to anything more than superficial change. In many cases, these are people who are, or at least believe they are, gaining some kind of benefit from, and are perhaps even directly responsible for, the behaviour that has been identified as damaging.
- Therapy and the green movement are both hybrids of science and art or 'religion', of intellect and intuition, of the thought and the felt. Though both are often described as wholistic, empathic or compassionate and concerned with quality of life, they both also often rely heavily on a scientific model. Psychology and psychotherapy have long done so and environmentalism has been doing so increasingly over the last two decades. This dichotomy has been translated into differences of practice in both activities. The insistence on scientific validity in therapy and psychological research is associated with the dominant orthodoxy of rational, verbal and serious therapies as opposed to humour, intuition, paradox and nonverbal behaviour as therapeutic tools. The environmental movement looks increasingly to science and experts to present their case and nowadays relies more on working groups, scientific evidence, submissions and parliamentary lobbying in preference to direct action, dramatic imagery and emotive argument.
- Both are areas in which supposedly 'irrational', at times apparently bizarre, methods are used, often with significant impact, but which are treated with suspicion or hostility not only by people from outside the profession or movement but frequently by representatives within

them. This thereby ensures confinement of the nonrational to being unusual and fringe anomalies within endeavours defined through reason and science.

Another common characteristic of the early stages of a PhD is the tendency for the topic to continue expanding before the realisation sets in that it has become multiple PhDs, each valid and fascinating in its own right but requiring three or more candidatures, not one. My research had moved on to increase the realm of personal and social change by looking at innovative ideas and practices in management theory and organisational change.

Though very different to psychotherapy and the green movement, change has become a key theme in the management of organisations and I felt recent significant shifts in theories of organisational change justified inclusion in my study. For most of this century organisational theory has been based on principles of scientific management, linear planning, rigid hierarchical structures and top-down communication. The theoretical shifts are now producing concepts of intuitive, paradoxical and 'new paradigm' management; proposals to apply ideas from chaos theory and complexity theory to organisational change; and calls for fluid, non-hierarchical roles and "empowerment" for the workforce. Similarities to the other two case studies emerge when attempts are made to turn these theoretical shifts into innovative practice in an organisation. Reluctance to change comes not only from management but all levels of the organisation and frequently what change does occur will end up being piecemeal and considerably diluted. However radical or 'new paradigm' a proposed change might be in theory, reason and habit can remain potent protectors of the status quo.

To justify the expansion of my topic, I identified some similarities between psychotherapy and approaches to organisational change.

- Both endeavour to change human activities and perceptions, either from ones considered to be problematic or to improve ones considered functional. This includes 'letting go' of old habits and becoming more flexible and able to deal with changes.
- Both mostly look at individuals functioning within systems though emphasis on the individual or the system will vary between psychotherapeutic models and organisational theories and priorities.

- In common with therapy and green activism, organisational change often attempts to facilitate change in the behaviour and thinking of people who may not recognise a need to change or, even if they do, become resistant to anything more than superficial change. In many cases, these are people who are, or at least believe they are, gaining some kind of benefit from, and are perhaps even directly responsible for, the behaviour that has been identified as damaging.
- The science-reason versus art-intuition-spirituality dichotomy can also be found in contemporary organisational theory. A number of recent approaches to management and organisational theory appear almost 'new age' with references to new paradigms, the 'art' of leadership, martial arts, intuition, creativity love, "leading from the heart" and spirituality in contrast to the 'hard' approaches to management which emphasise scientific management and rationalist concepts.

Eventually it was realised that attempting to treat all three case studies equally was much too cumbersome. The last to be adopted, organisational change, was the first to be sidelined and for some time I continued with both psychotherapy and green political activism as case studies though with the latter gradually receiving less and less attention as psychotherapy was proving to be a huge topic in itself. At this stage I developed a pilot semi-structured interview and conducted it with several therapists. As green political activism had not yet been officially sidelined, I adapted the interview and conducted it with a leading environmentalist. The interview questions and responses are included as an appendix. Soon after the interviews, psychotherapy was chosen as the major or sole case study, with an option to use the other two for cross-reference purposes. Political activism and organisational change would be interesting topics for subsequent study.

The selection of psychotherapy as the case study stemmed from the fact that psychotherapy has long been my primary professional area of activity, there is more resource material on psychotherapy, and there are more examples of absurdity in psychotherapy than in the other two case studies. Also, my preliminary research into the other two case studies was revealing green politics to be mostly devoid of absurdity and most interpretations of management theory into organisational practice to be superficial or even deceptive.

The difficulty in the green movement is that most activists end up feeling quite overwhelmed by how serious they see the problems being and how difficult it is even to be heard let alone actually influence meaningful change. Direct actions are often characterised by hostility, anger, and sometimes violence. Similarly, debates, public meetings and meetings with opponents tend to produce conflict and sometimes abuse. Not surprisingly, it is not unusual for even environmental groups' internal meetings to become heated and antagonistic. I have mostly found it considerably more difficult to incorporate humour into my political campaigns than my work as a therapist and even when humour does manage to weave its way into politics it more often than not takes the form of hurtful aggressive humour such as sarcasm or character assassination. When I was thinking of interviewing green politicians who use absurdity as part of their political strategies I contacted a close friend in Germany, who was at the time a significant player in Die Grunen (the German Green Party), asking him to identify some appropriate elected Green parliamentarians for me to request interviews with. After a couple of months discussing this with his colleagues in Die Grunen he advised me that, to their consternation, they had concluded that all of their elected members were too serious to be useful for my research. The situation may nowadays have become marginally less grim, including here in Australia where there are now several elected green members of federal and state parliaments, some of whom do seem to have a good sense of humour.

Despite the growth in management literature of interest in new paradigms, paradox, chaos, community, and 'intuitive management', there appears to me to be little application of these concepts in the workplace – at least not in Australian workplaces. If anything, workplaces appear to be becoming more stressful, competitive, driven mostly by 'bottom lines' and deadlines, evidence-based and reason-based. Strict deadlines and job insecurity do not provide fertile ground for intuition, innovation and risk-taking. In practice, 'scientific management', not 'creative management' or 'intuitive management', is still the dominant management paradigm.

CHANGE

The nature of change

There are some important questions to consider when examining personal and social change, such as:

- What is change?
- What kind of change is intended and what is actually occurring?
- What or who is shaping or driving the change?
- Whose interests are being served by particular changes?

These can be reframed into three general questions relevant to the thesis.

- What types or levels of change can occur in psychotherapy? For example, change can be conservative or radical; superficial or fundamental. It can be change to behaviour or conscious cognitions or it can be change to core beliefs or unconscious process. It can be change that keeps the person within a paradigm or takes them beyond (i.e. without) the paradigm.

- What is the relation between means of change and the type or level of change the means are capable of producing? Reason and science have become the dominant means of explaining phenomena, including human experience and behaviour, as well as the primary gauge of the acceptability or usefulness of change. I will argue that reason on its own can only lead to change within parameters acceptable and explicable according to the science-reason paradigm. Reason is unable to go outside the parameters it sets and therefore science can be revolutionary only when it escapes the confines of reason and stumbles upon something inexplicable by current methodologies. In such a moment the scientist must choose whether to:
  - ditch the incongruous data as false;

- somehow mould it into a shape congruent with current knowledge (assumptions, preconceptions) and accepted practice (reasonable, scientific methodology), in other words pretend to be doing science;
- or pursue the data into uncharted territory where reason on its own cannot go.

- How does the relationship between people involved in a process of change, such as that between therapist and client, influence the nature of that change process? For example, how do power and inequality of status influence change? Can change ever be fundamental when imposed upon someone or can it only be so when originating from the person undergoing the change?

Change and paradigms

Given the earlier reference to paradigms, a simple definition can suffice here: a paradigm is a way of conceiving and being-in-the-world. A dominant paradigm provides a representational system or shared reality that fosters 'common sense', shared meanings, a basis for moral systems and acceptable behaviours, and perhaps even social stability. It is all about being, and staying, the same. Is it then self-defeating, or at least extremely limiting, to use a dominant paradigm's basic principles and underlying assumptions, its 'common sense', as guidelines or parameters for change? How can change promoted or pursued within the limits moderated by a dominant system be anything more than what would be tolerable within that system, unless criteria from outside the system are brought into play?

Are the sets of (philosophical) assumptions or constructions about life underlying science-based, rational, linear approaches to change different to those underlying absurd approaches? For example, while reason implies, and can be applied with great pains to prove, a common truth or reality, absurdity conjures up multiple, ever-changing, unpredictable meanings and realities.

In what ways might different approaches reflect change agents' different beliefs about human life and society, perhaps in some cases even different 'paradigms'? Clearly, some change agents employing approaches to change seen as reflecting a radically different view of life than the

consensus, are doing so knowingly, and often explicitly, because they intend the consequences to be of a radical nature. These change agents and their methods are often labelled as "unreasonable" by most observers but the change agents do not consider themselves to be unreasonable because they are trying to change practices or institutions they consider unreasonable, damaging, even dangerous, in the first place. Given the change agents' perception of the target of change being unreasonable, the methods employed make perfect sense to them. What appears irrational, unreasonable or absurd from one perspective, does not necessarily appear to be so from another.

This is not to say that a person's use of one approach in preference to another inevitably reflects their preferred paradigm, philosophical sets, experiential sets, explanatory sets, or value systems. A transpersonal therapist or ecopsychologist may have a predominantly 'alternative paradigm' view of life but still employ approaches seen as scientific or rational at times. Likewise, a behaviour therapist may teach meditation. This also applies in research and academic writing, such as in my case of having to write reasoned prose, because that is the language and style of thesis writing, even though I am writing about the limitations of reason.

Types or levels of change

Change is not a simple concept or process and it occurs in different ways at different levels for different reasons. There are numerous different types of change and targets of change focused on in psychotherapy, such as whether change is:

- short term or long term;
- gradual or sudden;
- in behaviour, attitudes, cognitions, emotion, or self concept;
- intrapersonal or interpersonal;
- internally focused or externally focused;
- superficial or profound;
- conservative or radical;
- within paradigm or beyond (without) paradigm;

- personal, systemic, political;
- complying with or defying outside influence, including therapist's influence.

A theme running through these different types or levels of change is the difference between changes of degree, such as in the modification of something, or transformative changes of nature, metamorphosis. These differences were described by Watzlawick et al (1967, 1974) as "first-order change" and "second-order change". First-order change occurs within a system and does not bring about change to the system's structure or the principles by which it operates but arises from the use of established means consistent with this structure and principles. It tends to be linear, gradual and predictable. Second-order change is change to the system itself. It is often sudden, can appear illogical, and can lead to radical difference and unpredictable effects. Related to this is whether change occurs as a response to outside influence or internal momentum, and whether change occurs in order to adapt to external pressures or does so irrespective of external events or as a counter to external events. Does the change conform to and maintain established social or psychological structures or might it lead to changes in those structures?

The relation between change and the means to achieve it

Do the means or vehicles of change need to be radical to influence profound rather than superficial change? In this context, do reason and absurdity promote different types or levels of change? In their discussions of second-order change referred to above, Watzlawick et al (1967, 1974) saw paradox as the appropriate psychotherapeutic means to bring it about. As a case study, psychotherapy is characterised by dichotomies of types or degrees of change and of the methods employed to facilitate change. These dichotomies raise several questions worth mentioning here, even though they will not be fully addressed in this thesis.

- Can means or vehicles of change that are structured on or reflect the principles underlying, and thereby maintaining, a particular paradigm or belief system only lead to modifications to that paradigm or belief system? In other words would they be unable to lead to a transformation to, metamorphosis of, or transcendence beyond, those

underlying principles? Can radical change only emerge from means or vehicles that reflect fundamentally different principles? This question most obviously arises in relation to abrupt change but also needs to be posed in relation to change occurring more gradually where that change is intended, hoped or perceived to be of substantial degree.

- Are different sets of philosophical assumptions or constructions about life implied in science-based, reasoned, linear approaches to change and in approaches seen as absurd, paradoxical or humorous?

- What relationships can be established between what may be profoundly different approaches to change? How compatible can they be? For example, should humour and absurdity at most only be seen as adjuncts to the science-based and logical approaches to change, useful in drawing attention to the problem but not in themselves able to form the basis for change?

- What relationships can be found between the types or degrees of change achieved and whether the approaches to change employed were seen as rational and/or absurd?

- What are differences between approaches to change that are meant to conform to, maintain or modify established patterns of behaviour and approaches that challenge established patterns and aim for more profound and radical change?

- What can happen when people employ supposedly (conventionally defined) unconventional approaches to change conventional structures or employ radical approaches to change conservative, perhaps rigid, structures? What can happen when irrational (conventionally defined) approaches are employed to change behaviours or institutions justified and maintained by appeals to rationality?

- How can the different approaches to change affect and reflect dynamics in the therapist-client relationship, such as power, roles and status, the role of expert and who sets the

process and goals of change? For example, can reason be used as a means by which to maintain the status quo or, failing that, impose change onto the 'changee'? How do reason and absurdity influence who in the relationship becomes the source of change and can change be fundamental only if originating from the 'changee'?

TERMINOLOGY AND DEFINITIONS

As many concepts used in this thesis are not straightforwardly definable, I do not attempt to use single or simple definitions and, therefore, all contingencies and ambiguities are implied. For example, as discussed in the next chapter, 'humour' is not a simple, definable concept even though it is something universally experienced. The term "experience of humour" is too obscure in a research context and yet it represents a common occurrence. Nevertheless, some degree of definition is attempted or approximated during the thesis with key concepts such as reason, rationality, logic, absurdity, paradox, humour, paradigm, change, and psychotherapy. It is also worth repeating here that although I have tended to reify and personify reason, science and absurdity, and occasionally psychology and psychotherapy, it should be taken that I am referring to how people use, and are influenced by, these activities.

STRUCTURE OF THE THESIS

As stated at the beginning of this chapter the following discussion consists of two parts. The first, Chapter 2, is a conceptual discussion of reason and absurdity, how they reflect different paradigms, how they can influence knowledge and behaviour, and their role in change. The second part itself consists of two components. Chapters 3 and 4 offer an overview of the process and range of psychotherapy and a historical analysis, its basis in reason, and its discomfort with absurdity as a potential influence. Chapters 5 and 6 provide a detailed presentation of how psychotherapists can bring absurdity into their work. To my knowledge this compilation is considerably more comprehensive than any others published to date.

CHAPTER 2: REASON AND ABSURDITY

THE RELATIONSHIP BETWEEN REASON AND ABSURDITY

Some differentiation is worth making at the outset between reason and absurdity as means by which people can create understandings of their world and otherwise as means by which people can interact and communicate assumptions about behaviour and morality. Reason is the dominant influence on both of these aspects, at least in western industrialised societies and increasingly across the globe. As a means to understand, reason is the underpinning of scientific methodology and the search for a commonality governed by discoverable sets of laws through which humankind can make sense of the apparent complexity and multiplicity of phenomena. In contrast, absurdity implies multiple realities or an ever-shifting reality not necessarily patterned or emanating from any degree of commonality. As a form of communication and establishment of social norms, reason has become the basis of superior behaviour, sanity, social institutions and morality. Reason has also become the controlling orthodoxy in academic and professional disciplines such as medicine, psychology, law and economics determining research priorities, professional status and responsibility, allocation of funding, and political support. In psychology and psychotherapy, for example, reason-based approaches to research and clinical work dominate university departments and have become the only forms of treatment acceptable to medical, legal and funding bodies. Psychology and psychotherapy as orthodoxies have become embedded in the notion that they must be based exclusively on science. The orthodoxies become self-fulfilling and self-perpetuating as they dictate what is acceptable and what should be supported.

Reason and absurdity can function as foundations for belief systems, mental sets, paradigms, ways of experiencing, construing and acting in the world, and they can function as means by which people interact and thereby as spheres of influence and means to facilitate change. The implications of reason and absurdity appear to be very different and lead to several questions including:

- Are reason and absurdity antithetical or are they relative? Are they mutually exclusive or can they co-exist and, if they can, how?
- Do they arise from, or reflect, different views or conceptions of the world, for example how does each sit with different paradigms?
- Do they lead to different approaches to change and what different types or levels of change are achievable through each of them?
- How do they influence human relations, for example in regards to power and equity?

Whether or not reason and absurdity are mutually exclusive or can co-exist, it does seem evident that they are antithetical. Strict definitions of the terms, such as absurdity is "contrary to reason", places them as opposites. Similarly, their implications represent opposing views, such as with the unitary and knowable 'truth' or reality presupposed by reason or the ever-shifting unpredictable multiple 'truths' and realities implied by absurdity. Moreover their application suggests opposing stances. Reason planfully uses predetermined 'truths' as persuasion and "convincing force", and thereby control. In stark contrast, absurdity is playful, spontaneous and allows people to make their own sense or simply stay with nonsense. Reason readily serves as a means to control whereas absurdity fosters spontaneity. These are critical features when applied to psychotherapy but there is one more area of contrast that can have an even greater impact on the goals of psychotherapy. Dictionary definitions of reason refer to a psychological group of items including "sanity", "a normal mental state", and "common sense" thereby rendering absurdity as insanity, abnormal mental states and 'uncommon' sense. These definitions are discussed in more detail later in this chapter.

Even though antithetical, at one level of observation, reason and absurdity may be able to co-exist as modes of social behaviour and mental sets about the world. For example, absurdity can be a way to grab a person's attention and interrupt perceptual or cognitive processes as an opening for a new course of reasoning. Absurdity can also be a means to add an interesting twist or emphasis after a point has been made through reason. People can believe the world to be a rational place, that reason is the path to true understanding, and yet also behave at times with humour, act the fool, entertain absurd thoughts, or attempt to influence someone through silliness or nonsense. Likewise, presumably, people with absurd views or philosophies of life

can act reasonably if need be, though this might require a greater leap of consciousness, or leap of faith, than it would take for a reasonable person to act absurdly.

From a different perspective, and particularly from the perspective of reason itself, reason and absurdity can appear to be mutually exclusive, reflecting irreconcilable ways of being-in-the-world. However chaotic it might appear on the surface, the universe is understood by reason ultimately to be ordered and governed by laws potentially discoverable by science and reason, with the apparent multiplicity of phenomena concealing an underlying commonality and single reality. Reason and science are the means to truth, sensibility, order, sanity and objectivity unsullied by emotion. Absurdity on the other hand, from the perspective of reason, is foolish fantasy and fragmentation that leads to disorder, chaos and, potentially, madness. It is self-contradictory, confused, subjective, emotional, impulsive, individualistic and self-obsessed. It wants its cake and to eat it too, such as in its implication that there are many realities each with its own validity. It throws sensible thinking and dialogue off its logical track thereby preventing clear thinking and effective communication. From its place at the pinnacle of knowledge, reason gives no space to absurdity or any other alternative approaches to understanding the universe. As the dominant paradigm it is simply believed to be the sole path to truth.

From the more flexible and accommodating position that "there is more than one way to skin a cat", the co-existence of reason and absurdity may be conceived as possible. Trying to see how they might do so depends on whichever of the following three positions one adopts:

- absurdity is ultimately inferior, at best an adjunct, to reason as a way of construing, and acting in, the world;
- absurdity is as useful and functional a way of construing, and acting in, the world, as reason;
- absurdity is superior to reason as a way of construing, and acting in, the world, especially as a means to radical shifts in perception and behaviour, and has the potential to transform how humans relate with each other and with the non-human world.

With the first position, absurdity either has no role or it becomes a plaything of reason, perhaps as a distraction or an aside; a temporary relief; or at best it may be drawn out as a foil to reveal

reason's pre-eminence. With the third position, absurdity could be revolutionary – mocking and undermining the assumptions and consequences of reason; undermining its foundations; ridiculing the irrationality of rationality and the unreasonableness of reason. In this case, absurdity may have the potential to transform how humans relate with each other and how humans relate with the non-human world. Paradoxically, reason needs absurdity to stop it from becoming unreasonable. If allowed to run without check or counterbalance, reason and science can lead to disastrous consequences. Misinformation, false premises and ignorance can lead to disaster however logical the path there may have been. Reason is locked into a sequential path requiring each step to be consistent with the previous step, but if any premise or step is faulty reason logically and blindly progresses towards faulty, and potentially disastrous, conclusions. Reason needs absurdity to challenge and lampoon its process and assumptions but while reason is held to be the only valid means to knowledge it can never be receptive to the counterbalancing influence of absurdity. This is represented as the paradox of reason in Chapter 7.

Realistically, absurdity is unlikely to gain supremacy over reason as the primary vehicle to construing and acting in the world, at least not in a world pervaded by science and technology. The second position above is probably the most viable, in which absurdity is credited with as much value as is reason, even if reason still gains most 'airtime'. That would be a considerable improvement for absurdity on its current status as irrelevant at best and dangerous at worst. With equal value, when the laughter has died down, and reason is returned to, the experience will be felt to have been worthwhile heuristically rather than a mere distraction.

Though life is really, or appears to be, still full of absurdity, the powers of reason and science have usurped and suppressed absurdity, nonsense, folly and intuition. The supremacy of reason, at the expense of absurdity, came about through western society's, and eventually the world's, march to modernity. It began in earnest with the Enlightenment, the 'Age of Reason', though its roots can be found earlier, for example in the rationalism of Puritanism, and the concept of rationalism can be traced back at least to Plato and Aristotle and perhaps even pre-Socratic philosophy. In the Enlightenment reason was seen as the civilising force to lead humanity out of the dark ages of myth, magic and superstition into the light of the modern

world of science and rationality. In his sociological study of traditional folly, Zijderveld (1982) identifies modernisation and its rejection of traditional models of magic and myth as the downfall of absurdity, such as in the roles of fool and shaman.

> Rationalization means that the margins of reality, where the meaning, values and norms of daily life lose their power, are progressively reduced while rational planning and calculability take over command. In the calculable world of Rational Man there is no room left for the spuriousness of the fool. Certainly, whenever Rational Man stumbles or staggers, whenever the rationality he has to offer seems to lack relevance and meaninglessness, whenever in short society grows abstract, the fool may rise from his ashes again, offering traditional enchantments to culturally discontented modern individuals. During the 1960s the hippies of America and the provos of the Netherlands re-enacted the social roles of traditional fools.
>
> But such re-enactments of traditional folly are doomed to remain interludes in an otherwise thoroughly disenchanted world. Rationalism will remain the heart of modernity and as long as society remains modern, folly will be banished from its core, pushed aside by forces which are outside its control (p. 32).

Reason's rise to dominance, and the entrenchment of science-reason as the dominant paradigm, have led to the replacement of absurdity's traditional aura of magic, discovery or liberation (such as from evil spirits, sickness or ignorance) with its modern characterisations of immaturity, silliness, stupidity and even insanity. Suggestions that absurdity could be a potent therapeutic tool have tended to be met with derision or suspicion by professionals in psychotherapy, psychology and psychiatry, although favourable responses have been gradually becoming more common in the last two or three decades.

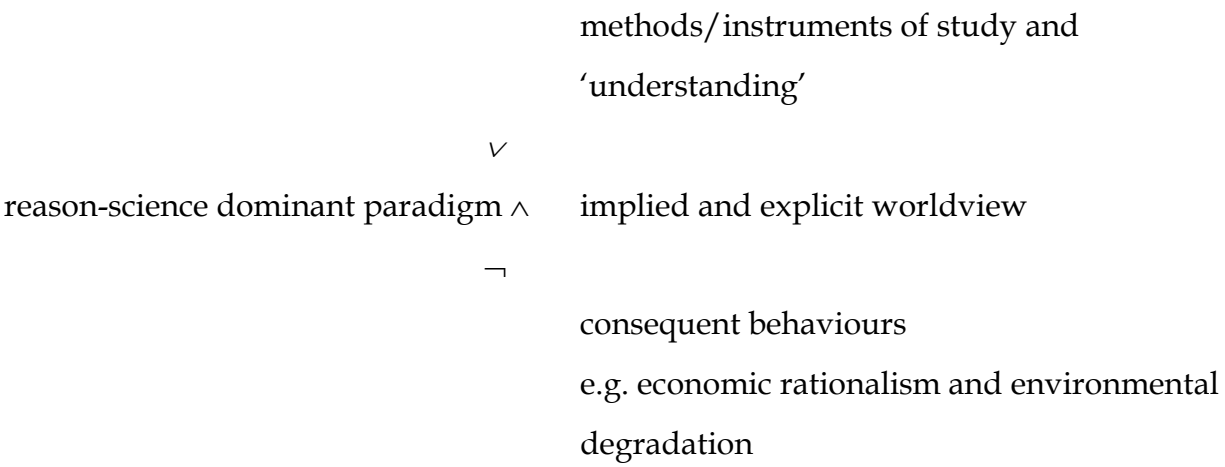
REASON AS A MEANS TO KNOWLEDGE

Is the world governed by a natural order based on principles of reason, and thereby discoverable through the application of reason? Or is the application of reason, as a methodology to try to understand the world, simply a system of thought created by humans and projected onto a (perhaps unreasonable) world in the attempt to make sense of it? Is the world ultimately a rational, structured, orderly place or is it otherwise but with the ideas of rationality, structure and orderliness superimposed upon it by the human mind? The

superimposition of rationality, structure and order is also upon people, as reason is the measure of normality and sanity and thereby the means to prescribe and proscribe how people should think and behave. If reason is purely a human endeavour it has become the most successful model for conceptualising the world, culminating in science as the dominant means for creating knowledge and the science-reason paradigm as the dominant paradigm applied throughout intellectual, political and economic activities.

Much of western philosophy, at least since Plato, has portrayed reason as both the means by which to understand the supposed natural order of the universe and the basic principles on which it is based. In other words, however diversified and at times random phenomena may appear, reason postulates an underlying ordered commonality that can be discovered and understood through the systematic application of reason itself. Reason assumes, searches for, and 'discovers' order, structure, basic principles and laws, and thereby predictability, in the world. The word 'discovers' is in scare quotes here because while advocates of reason as the only credible source of knowledge would see it as a means of discovery, the sceptic could argue that reason invents or projects these concepts onto the world and, as such, may simply be just one, albeit very successful, means by which to create, rather than discover, knowledge. Reason is, after all, an indirect contact with phenomena, mediated by thought, language and the structure of logic and linearity. Other modes of 'knowing' appear to be based more on the direct experience of phenomena. Some of these alternative modes, such as mystical experience, the phenomenological epoche, intuition and, perhaps, irrationality or absurdity, might be just as valid as reason as means to interpret the world.

The scientific pursuit of knowledge is based on the presupposition that reason is the means by which to find it. Science can only 'discover' that which its method is able to lead it to. The science-reason paradigm provides understandings of the universe that are consistent with its basic assumptions and descriptions. Reason begets only that which falls within the limits of what is reasonable by its own definition. The 'understanding' produced by reason reinforces its own explicit as well as implied worldview and generates behaviours consistent with that, even where those behaviours are patently wrong when judged by methods other than reason. This can be portrayed diagrammatically.



This indicates a second problem, the assumption that reason can only be reasonable. The mistake arises from semantics. Reason is reason-able in the sense that it is only able to be reason, to do what it is designed to do, which is its limitation, and danger as a means to knowledge and as a means to change. It is because of its limitations, however, that reason can produce unreasonable beliefs and lead to unreasonable actions. Reason can lead to outcomes that are absurd, in the sense of 'absurd' as "obviously false; comical; laughable", though the devastation this can cause soon overshadows our ability to laugh at it. Outcomes range from the individual, such as in the anguish people can cause themselves through following lines of reasoning and rationalisation based on false premises to the global, in the possibly irreversible destruction humankind has wreaked on the natural environment using the tools of science and reason. Science justifies itself, and justifies its reason-base, by ignoring or rationalising its irrationalities and absurdities. This is what was meant by the earlier statement, worth repeating here.

Paradoxically, reason probably needs absurdity to stop it from becoming unreasonable. If allowed to run without check or counterbalance, reason and science, can lead to disastrous consequences. Misinformation, false premises and ignorance can lead to disaster however logical the path there may have been.

Perhaps it is also a paradox that while science and reason are used to create answers to problems, they stimulate ever more questions and create more problems.

Having said all this, it is not my intention to portray reason, rationality, logic and science as inappropriate tools for making sense of the world. To do so would itself be inappropriate given the enormously useful role they, and especially science, have played in shaping the modern world. What I am attempting to do is to point out limitations and risks of endowing the reason-science paradigm with the sole, or at least ultimate, validity as source of knowledge and guidance for action. Though reason and science have produced solutions to many problems, they have also created problems, as seen in the many environmental crises occurring around the world. The paradox is that reason contains and conceals irrationality or absurdity and that unrestrained reliance on reason is irrational or absurd.

DEFINITIONS AND FORMULATION OF REASON

Definitions of reason tend to highlight three aspects of the concept. Some of the following expressions are taken directly from various dictionaries.

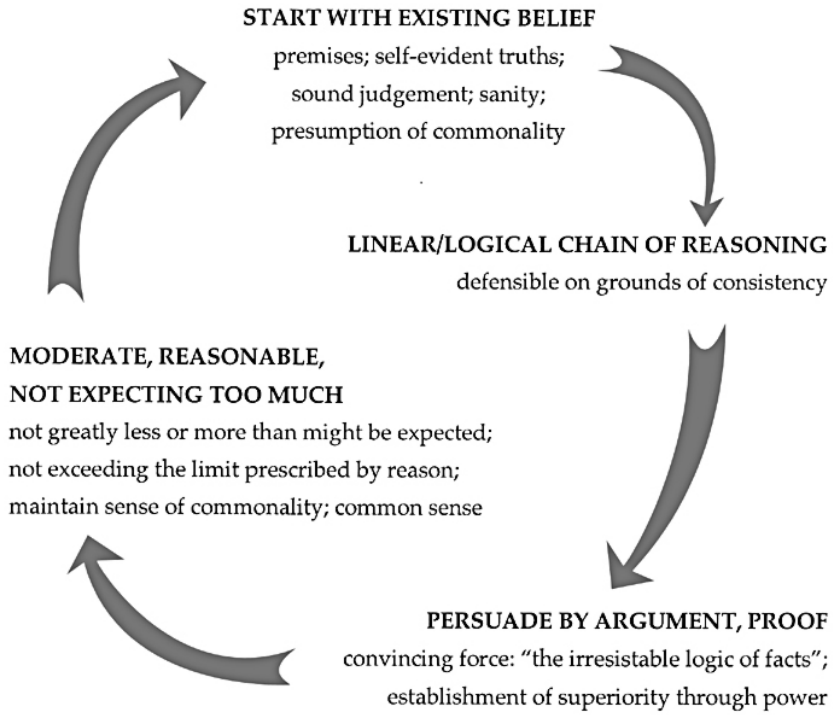
- Reason is a mental faculty or a method for deriving conclusions or inferences via a process of logical, linear, consistent thinking from premises considered to be facts or self-evident truths. Self-evident truths are assumed to be true because there is general acceptance they are true.
- Reason is a method of presenting 'facts', 'truths', conclusions, inferences as a means of logical argument and persuasion to prove or disprove, or to justify or condemn, an opposing belief or action. Here logic is seen as a means to prove and convince: a "convincing force" through the "irresistible logic of facts" (Macquarie Dictionary).
- Reason is the basis for sound judgement, sensible conduct and sanity. From this arise criteria for what is reasonable, such as not exceeding the limit prescribed by reason, maintaining moderation, not greatly less or more than might be expected. To be reasonable is to conform to limits judged appropriate according to pre-set or implied criteria.

A significant implication of these definitions is that a linear, consistent chain of thought, conforming to the laws and principles of logic, is the superior or only means to gain 'knowledge

of facts' and, as such, should be used as a "convincing force" of argumentation and persuasion to overcome opposing inferior points of view. Superiority, power and persuasion and, through them, control are inherent in reason.

Another implication is that the conclusions or dominant points of view derived from this process will conform to conventional limits of what is considered moderate and appropriate. The validity of all points of view and argumentation, and criteria of soundness of mind and sanity, are measured against these limits and dominant points of view. Reason is inherently conservative.

This is a self-perpetuating process. It starts with assumptions believed to be self-evident truths, follows a strictly defined process of thinking to conclusions consistent with the initial 'truths', and uses persuasion to establish the superiority of established points of view, worldview and conservative codes of conduct. Herein are implications of commonality, order and fundamental laws underlying existence and also a rationale for morality and acceptable conduct based on prescribed limits of moderation. This is what is usually being referred to by the term 'common sense'. This can be schematised in the following way. How ironic that the linearity of reason, and associated concepts of progress and cause - effect, can be depicted as ultimately circular, self-pesssrpetuating and self-fulfilling.



Reason cannot move outside the limits prescribed by itself as if it did it would, by definition, become unreasonable, irrational, illogical. The chain of reasoning becomes a self-contained, self-limiting, self-fulfilling knowledge system assuming superiority over all others. In light of this, reason is not a tool designed to bring about fundamental change, only change along a continuum of what is acceptable, change that is essentially more of the same.

Differentiation needs to be made here between the term 'reason' as definition and the application of reason as a process. I have been discussing the limitations of reason as a means to significant change but this is not to say that a person cannot begin with reason and subsequently arrive at a significant shift in perspective or change in behaviour. As seen above, by definition reason cannot lead to profound change or new perspectives outside its linear processing from original premises. The reality is that people do apply reason and arrive at conclusions outside the boundaries they started with. From a definitional standpoint it would have to be assumed that reason made room for absurdity in some way for this to have happened. For example, through reason a scientist might reach a point at which the data, phenomena or ideation appears to be paradoxical. Contemplation of the paradox might lead to a profound shift of perspective and though the process may appear to have been reasonable it would have had to allow the paradoxical components to co-exist before finding a way beyond them. Definitionally, reason cannot permit this but, depending on how it is applied, the process of reason might.

It is not only the self-limiting nature of reason that works against fundamental change. It may be that change can only be fundamental if it arises from the 'changee', the person who is seeking change. Reason can become an instrument for devaluing and negating change arising from the changee by providing another person (who, for simplicity's sake, I will call the 'changer') with a means to impose their own view of change onto the changee, to persuade and convert the changee with "the irresistible logic" of the changer's 'facts', and to assert their superiority. This would be a problem in psychotherapy which is supposed to be a means through which changees, clients, come up with their own insights and ways to change. The fact is that reason does play this role in a great deal of psychotherapy sessions, in my opinion the vast majority of them. A question here is whether absurdity can be used in the same way or when it appears that

it is being used this way is it really reason masquerading as absurdity? These issues are returned to later.

REASON'S PRESUMPTION OF ORDER, COMMONALITY, AND SELF-EVIDENT TRUTHS

Reason implies, and can be applied with great pains to prove, a single truth or reality, whereas absurdity conjures up multiple, everchanging, unpredictable meanings and realities. Reason and logic are seen as means by which to 'discover' or 'uncover' an underlying commonality to reality rendering it thereby measurable and able to be understood. This has been the dominant theme in western philosophy since the ancient Greeks and has formed the underpinning of modern science. Commonality also implies order and the belief that however chaotic, spontaneous or unconnected phenomena may appear from a naïve viewpoint they can be understood as subject to laws and regularity when studied through science and reason.

The belief epitomised through reason, that the universe is ordered and governed by natural laws, also implies a moral position. Reason becomes not only a means to knowledge but a means to morality and conversely that which is against reason, such as absurdity, represents the immoral. Absurdity has often been depicted as immorality and disorder, such as when it appears as spontaneity, inconsistency, having fun, and even in laughter. Reason presupposes laws of nature and order and implies a morality based on not straying beyond the limits set by those laws and by maintaining order. It is unreasonable, irrational, to go beyond those limits and that which is beyond those limits is irrational, a threat to order, and perhaps insane (which is a component of the definition of irrational). In his study *Modes of Irrationality: Preface to a Theory of Knowledge* (1971), Garelick highlights the dominance of this theme in western philosophy.

The moral meaning of rational also makes clear the justification for reason's use; it is a justification that has dominated the history of philosophy until, at least, Nietzsche. The failure to abide by the discovered affinities results in self-destruction. Since the universe or significant parts of it move by some kind of order, and since no

conatus desires its own destruction, unless already overwhelmed and made "senseless", we ought to be rational. By following reason we will achieve happiness. Or at least that portion of it allotted to man. There is value in leading the rational life, for reason enables us to see the order and regularity which guides the universe – and determines man's fate (p. 7).

Eastern philosophies often paint a different picture that can appear irrational, even absurd and bizarre, to westerners. Although reason dictates a linear progression from premise to conclusion, what are considered reasonable premises can vary between cultures. In other words, concepts of reason, reasonableness and rationality are culturally relative and what might be seen as rational in one culture could be considered irrational in another. Moreover, in some cultures to follow a straight line of thinking would itself be considered irrational and not useful as a means to understand and represent the world. The problem is that reason is self-justifying and becomes the correct way, the truth, in accordance with its own criteria or definition.

Within a culture, certain beliefs or actions are thought to be reasonable in the sense of being socially acceptable, comprehensible, and for which the reasons make sense within that culture's norms and meaning/belief systems. Mirroring the reasonable are other beliefs and actions seen as unreasonable, in some cases so much so they may be classed as insane or fuelled by evil forces. Each culture has its reasonable and correct ways to understand and act within its world. It may be that some cultures are more tolerant of alternative beliefs and behaviours, those considered to be irrational or abnormal according to that culture's dominant criteria for rationality and normality. Also, within any culture there will be multiple, shifting, mutually influencing experiences and beliefs of individuals and sub-cultures.

The danger arises when a culture's dominant view of 'reality', of what is acceptable and reasonable to believe, condemns all alternative views as irrational, ridiculous, unhealthy and wrong. This reflects the assumption of a universal truth, but what may be a universal truth in one culture can be an absurdity or sign of madness in another. The reason-science paradigm has become entrenched as the dominant global 'reality' to be held as absolute, the one truth or at least the one vehicle to obtain truth. Given the relativity of concepts such as reason and normality, and the transient nature of humankind's 'knowledge' of, or representations of, the

world, the aggrandisement of reason to the status of absolute can be seen as itself unreasonable, even absurd.

The existential philosopher Albert Camus saw this as the absurdity of western philosophy and culture since Plato. In his view, the reliance on reason as universal truth reflects an absurd attempt to deny the anxiety arising from our existential confrontation with the multiplicity and transience of life. He saw any attempt to analyse our finite existence through reason, to seek reasons for it, as a fundamental absurdity. This is the absurdity of our constant striving to "make everything clear" even though the existential experience of "nothingness" and "meaninglessness" confronts us with the impossibility of being able to "make everything clear". Reason's presumption of commonality reflects our desire for absolute truth. Camus was not saying reality has no absolutes, but pointing out the absurdity of relying on a belief in absolutes while experiencing life as filled with multiple 'truths', contradictions, paradoxes, the inexplicable, chaos, finitude and impermanence. For Camus, the paradoxes and the absurdity arise from our reliance on reason as an absolute requiring our denial of the absurdity of our actual experiences of the world.

> The very simplicity of these paradoxes makes them irreducible. Whatever may be the plays on words and the acrobatics of logic, to understand is above all to unify. The mind's deepest desire, even in its most elaborate operations, parallels man's unconscious feelings in the face of his universe: it is an insistence upon familiarity, an appetite for clarity…That nostalgia for unity, that appetite for the absolute, illustrates the essential impulse of the human drama (Camus, 1955, p. 21).

REASON OR ABSURDITY

Absurdity can be a way to contradict, oppose, perhaps expose, reason's presumption of order, regularity and commonality. In this way absurdity can also be defined as contrary to 'common sense'. In his study of irrationality, Garelick refers to the historical trend of rationality and reason being the search for an underlying order to all phenomena and contrasts this with "non-rational modes of knowledge leading to anti-rational truths" (1971, p. 28).

If there is a formula for reason, so is there one for the irrational. If reason is an instrument for ferreting out affinities, the irrational must be that which is 'against' commonality and order, some element hostile to the principle of ordering (Garelick, 1971, p. 8).

Garelick then refers to philosophers, such as Schopenhauer and Kierkegaard, who link irrationality with passion and portray them as potential means to knowledge and, for Kierkegaard, essential to being a fully authentic person. Garelick refers to Kierkegaard's view of the irrationality of passion being in opposition to the use of reason to present reality as an ordered whole, pointing out that for both of these philosophers:

….irrationality is the hostility of the passions to ordering. Passion is free-floating: it does not lead to any end. Passion, then, is the enemy of teleological order. Reason attempts to impose just such a *telos* upon all of existence and passion, but fails, leaving us with only the illusion of directed passions (1971, p. 22).

Absurdity does tend to inspire emotional responses, passion, engagement, energy. It is usually unpredictable, or at least appears to be, often arising spontaneously and triggering spontaneous responses. This stands in stark contrast to the basic goals and principles of reason such as predictability and objective analysis not compromised by emotions. The ability to become more spontaneous, less self-controlled or controlling of others, is not an uncommon request presented by clients to psychotherapists. How reason-based therapy would approach this request will obviously differ to how absurd therapy would do so. Spontaneity is often, perhaps always, a feature of absurdity whereas it is rarely, perhaps never, a feature of reason. It seems fair to say that spontaneity does not sit comfortably with reason but can it be claimed that spontaneity can never be a characteristic of reason? What does this imply about modern civilisation based on reason, for example can it be seen as reflecting a form of 'disenchantment' or loss of the 'enchantment' of anti-reason and anti-science activities such as magic, spirituality, or absurdity?

Another contrast between reason and absurdity is the argument that reason always involves a power imbalance and the question of whether absurdity can also do so or if 'genuine' absurdity, if there is such a thing, will always annul power imbalances. If this were so, absurdity involving a power imbalance is not really absurdity but reason masquerading as absurdity. Relating this

back to the previous paragraph also raises the question of how spontaneity can occur within power-based relationships.

An example of an apparently absurd therapeutic intervention is when a therapist communicates to a client, either overtly or covertly, that she should "be spontaneous", which also has an implied message that to be spontaneous is a good thing. The apparent absurdity stems from two things. The injunction is not simply a contradiction but a 'double-bind' (Bateson et al, 1956), as discussed in Chapter 5, as the person with (at least implied) power, the therapist, presents two mutually incompatible conditions that the client is required to respond to one way or another. The client cannot not respond. The absurdity also arises from how the injunction does not predetermine the outcome as the client can choose how to respond by being spontaneous, continuing not to be spontaneous, or pretending to be spontaneous.

In therapy this would still maintain a power imbalance with the therapist giving an injunction to the client who has to respond in some way. Does this indicate an example of reason masquerading as absurdity? On the other hand the client can determine how to respond. Of course there are degrees of power imbalance. In the case of minimal imbalance based on benign power aimed at clients finding their own sense of power and independence, clients will feel free to choose their own response. Perhaps the intervention can be seen as absurd in these cases. Where the therapist exudes an impression of power that influences clients to make choices that will satisfy the therapist, the intervention can be construed as reason masquerading as absurdity.

Perhaps such a masquerade reveals reason's envy or fear of the potential power of absurdity. Absurdity poses a threat to reason's goals of consistency, order and predictability. Historically reason has often not only been masqueraded as absurdity but been used to colonise it and control it. Berger, for example, points to Ancient Greece describing how the passionate spontaneity of Dionysian comedic rites had to be controlled and compartmentalised by the orthodox followers of Apollo, the god of reason and light. The absurd, in this case spontaneous and passionate comedy, is a threat to the seriousness and piousness of reason that must therefore be contained.

> The comic experience is ecstatic, if not in the archaic sense of a frenzied trance, in a mellower form of *ek-stasis*, "standing outside" the ordinary assumptions and habits of everyday life. The comic experience is orgiastic, if not in the old sense of sexual promiscuity, in the metaphorical sense of joining together what convention and morality would keep apart. It debunks all pretensions, including the pretensions of the sacred. The comic, therefore, is dangerous to all established order. It must be controlled, contained in some sort of enclave (Berger, 1997, p. 16).

Can something be considered *truly* absurd only if it is totally devoid of reason or can something still be considered absurd even where reason for it can be found in some way? If it is the former, can psychotherapy ever be *truly* absurd? Is it possible or feasible to practise psychotherapy without any rationale, 'without rhyme or reason'? A therapist acting the fool with their client for no *apparent* reason can certainly be seen as absurd. Is the act still absurd when, even if the client is unaware of any reason for it, the therapist is clear about the reason for doing it? Perhaps conferring the status of absurdity onto an action should be based on the process leading to, or at minimum immediately preceding, the action rather than whether or not any sense can be made of it after its occurrence.

To advocate a total absence of reason(s) in the therapy process can quickly conjure up fears of it reeling out of control, becoming truly 'crazy' and at risk of dumping any ethical constraints arising from rational thought or, at least, going beyond what would be generally considered reasonable. Any approach to psychotherapy unable to be supported by reasons for doing it (that is to say, inexplicable according to reason) is likely to attract labels meant to demean, such as "fringe", "invalid", "unprofessional" and "unethical". Presumably, this would include any therapeutic intervention to which the client responds with a shift of perspective or behaviour but neither therapist nor client are able to identify an obvious chain of linear causality from therapist's action and client's shift. From the perspective of reason either a sufficiently thorough investigation will reveal a linear causal link, thereby making the occurrence explicable by reason or science, or the occurrence must be given a pejorative label as described above. Absurdity poses a threat to the presuppositions of reason and so must be diminished, deprecated and invalidated.

THE ABSURDITY OF A REASONABLE WORLD

Life is teeming with absurdity even when it appears to be reasonable and people are continually confronted with paradoxes, possibly more than ever before in the history of humankind. Humour and laughter are universal experiences and behaviours in humans. Everyday life is filled with funny, bizarre, perplexing and surprising experiences. Though different cultures might find different things funny, all cultures have the concept and experience of the comical. Though senses of humour can vary between cultures, laughter is the same contorting breath-taking activity and experience all over the world. Every culture has jokes and the same jokes, culturally modified, can often be found in very different cultures.

Even some animals, such as primates, dogs and rats, exhibit behaviours that appear to be smiling and laughter in response to tickling or social play. Whether or not animals can be said to have a sense of humour, or at least be able to identify something as funny, is a more complex question. This question is made all the more complex by the difficulty defining concepts such as 'humour' and 'funny'. Nonetheless, some of the primates do appear to be able to recognise and communicate something as funny, in some sense of the concept. For example, there have been numerous studies of chimpanzees and gorillas taught signing as means to communicate with humans showing their ability to recognise abstract concepts and classes of things, including humorous or funny. The most popularly known signing primate is Washoe, taught signing by Allen and Beatrice Gardner in the 1960s. The following example, related in a personal communication from Roger Fouts to Paul McGhee, would appear to be an indicator that some primates are able to identify experiences and initiate behaviours as humorously entertaining.

> Washoe urinated on Roger one day while riding on his shoulders. Immediately after this act, she signed "funny" in a self-congratulatory way. This example is especially interesting because of the repeated snorts (breathing through the nose with a snoring sound) made by Washoe while repeating the "funny" sign. Whether this was a humorous occurrence to Washoe is debatable, but the closeness to children's behavior under similar conditions is undeniable. Washoe seems to have thoroughly enjoyed the incident (McGhee, 1979, p. 118).

Peter Berger describes the ubiquity of humour as "… weaving in and out of ordinary experience … of quite ordinary people ..." (1997, p. 5). He illustrates this with the beginning of a day in the lives of John and Jane Everyperson:

> They wake up in the morning. John is one of those people who wake up instantly, jump out of bed, and are ready to go. Jane is of the other kind, the one who wakes up slowly, reluctantly, not out of laziness but because waking reality seems quite implausible as she reencounters it. She wakes up, sees John prancing about (perhaps he does morning push-ups, or perhaps he is just purposefully going about his *toilette* and the serious task of getting dressed), and the sight seems quite ludicrous. Perhaps she laughs, or perhaps she supresses laughter out of marital delicacy (after all, this absurdly active individual has just emerged from *her* bed and is *her* husband), but the fact is that the first conscious thought in her mind that day is a perception of the comic. John, let us assume, comes to the comic a little more slowly (activists usually do). But he does make a joke at breakfast, perhaps about the toast he has just burned, or about the couple in the adjacent apartment (the walls are thin) who can once again be heard making love in the early morning. Then the Everypersons' young children come in, pretending to be the monsters they saw on a television show last night, and now everyone is laughing. Then John and Jane read the newspaper, he laughs at a cartoon; she makes a sarcastic comment about the latest folly of the government. All these expressions of the comic – and, mind you, they haven't even finished breakfast yet! (1997, p. 5).

Absurdity is both a very personal and shared human experience that stands in contrast to what ever it is we mean by the term "common sense". People find themselves imagining, thinking and doing absurd, bizarre, ridiculous, illogical and foolish things and can either laugh at themselves for this, put themselves down for it, or become fearful about what they think it might mean, which ironically would itself usually be an absurd thing to do. Given the ubiquity of absurdity it is strange that not more has been written about it by academics and professionals, particularly psychologists and sociologists. This peculiar absence is discussed later in the context of psychotherapy.

ABSURDITY AS ALTERNATIVE PARADIGM

If reason and absurdity are antithetical, and reason is the presupposition of science forming what I have called the dominant science-reason paradigm, does absurdity represent an alternative paradigm? Presumably, an alternative paradigm would be judged as absurd when,

according to science or reason, it appears to be inexplicable, illogical, nonsensical, contrary to reason or irrational. As soon as an alternative paradigm is provided with science-reason explanations it ceases being an alternative paradigm. This can become a means by which the science-reason paradigm is used to colonise or extinguish activities stemming from alternative paradigms and it is a risk that faces representatives of those activities who attempt to incorporate scientific and reason-based explanations in an attempt to gain greater respectability and recognition. Examples of this are traditional explanations of alternative therapies being replaced by supposedly scientific ones and the increasing tendency of environmentalism adopting science and reason to get across its message in preference to presenting its case in terms of ecophilosophy and ecocentric ethics.

Non-orthodox phenomena, especially those characterised by absurdity, can be difficult, perhaps impossible, to pin down for long enough to submit to scientific scrutiny. The determination to explain "Life, the Universe and Everything", according to criteria of science and reason, has thus far been unable to stem the spill-over of the inexplicable and the absurd, in other words that which appears to be inexplicable or absurd in face of the failure to explain it by science or reason. The question is whether reason or science can be adequate means to study and understand absurdity. Given that science itself appears to be full of absurdities how is it applied to study these? As mentioned earlier, reason left to its own devices can lead to very unreasonable, irrational outcomes, but how well can it be used to understand and expose this? Science and reason are powerful tools in their own right and can be used to address these questions, but to what limit? There must be a point in absurdity where reason is unable to go and other forms of enquiry and explanation are needed. For example, a Zen koan remains nonsensical however much reason is applied to it. Only by abandoning the search for reason will its meaning be grasped. Thus absurdity throws into relief the limitations of reason and the dominant paradigm of science-reason.

From a position of absurdity, reason and science appear absurd as they are taken so seriously and are so uncritically believed. Things that cannot be explained within the limits of reason and science have to be rejected or classified as inconsequential. Reason is the real culprit here

because it has to maintain itself within the confines discussed earlier. The challenge for science is to step beyond those confines into the unpredictability of absurdity.

> The importance of nonsense hardly can be overstated. The more clearly we experience something as "nonsense", the more clearly we are experiencing the boundaries of our own self-imposed cognitive structures. "Nonsense" is that which does not fit into the prearranged patterns which we have superimposed on reality. There is no such thing as "nonsense" apart from a judgmental intellect which calls it that (Zukav, 1986, p. 140).

DEFINITIONS AND FORMULATIONS OF ABSURDITY

Definitions of absurd and absurdity include it being something, such as a belief or an action, that is inherently inconsistent or something that is contrary to that which is socially accepted as normal, that does not conform to established standards. Dictionary definitions (Oxford and Macquarie Dictionaries and the Encyclopaedia Britannica) include the following:

Against reason

- unreasonable; contrary to reason or common sense
- logically contradictory
- out of harmony with reason or propriety
- inharmonious; out of tune; jarring
- inconsistent

Abnormal

- contrary to common sense or received opinion
- conflicting with preconceived notions of what is reasonable or possible
- deviating from the normal
- nonsense; nonsensical; senseless
- incongruous;

Comical

- comical; laughable; playing the fool
- obviously false or foolish; ridiculous; silly

Although this general concept or definition of absurdity can be used in the discussion of psychotherapy and processes of change, it may be too general to be useful when looking for specific examples in psychotherapy. In this event, the focus can become more on specific activities falling within the realm of the absurd, such as humour, playing the fool, paradox, irony or satire. A full list of absurd activities to be found in psychotherapy is presented, with examples, in Chapters 5 and 6. As paradox and humour are the two examples of absurdity in therapy mostly discussed in this thesis, some brief mention of definitions and theories are included here, before a final schematisation of absurdity is provided. More extensive descriptions are given in Chapter 6 where paradox and humour are viewed in relation to psychotherapy.

Paradox

A paradox usually involves a statement that goes against normal opinion, belief, expectation. Definitions describe paradox as exhibiting contradiction or conflict with preconceived notions of what is reasonable or possible, deviating from what is considered to be normal, and difficult or impossible to reconcile with basic premises of science. A paradox appears to be self-contradictory, as it presents two apparently contradictory notions as being able to co-exist. Despite this, there is often an implication that underlying the contradictoriness is some possibility of 'truth', that the contradictions can indeed co-exist however illogical this may appear to be. This is an implication of co-existence of multiple realities and possibilities, also an implication of absurdity in general.

Paradoxes are out of the ordinary, contrary to reason and therefore absurd. Paradoxes are often startling and grab attention. As they can short-circuit habitual thinking they have the potential to provoke fresh thought and innovatory insights. The mechanisms of paradox are essentially the same as humour and both are aspects of absurdity. They are both self-contradictory; use juxtapositions; imply multiple 'truths'; can be fantastic; arrest attention, create surprise and provoke fresh perspectives.

Theories of Humour and Laughter

Most of what has been written and theorised about why and how humour works and what purpose it serves has been by anthropologists, physiologists, literary analysts and philosophers. Many of the major philosophers have contributed to the topic and this has led to an array of theories of humour and subsequently to various classifications of these theories. Keith-Spiegel (1972) suggested an eight-point classification but acknowledged that, due to the complexity of the task and the tendency for some of the theories to "leave us perched atop a 'black box' (e.g., humor as an instinct)" or "to complicate rather than unravel this Gordian knot" (p. 4), hers was just one of a number of possible systems. Nevertheless, Keith-Spiegel's offering is quite comprehensive and her headings have been borrowed many times since. Here is a summary of her classification, together with some comments of mine relating to the inability of each of these single theoretical explanations being sufficient as a global explanation of humour.

- **Biological, instinct & evolution theories** are based on the assertion that laughter and the potential for humour are innate or instinctual and have adaptive or utilitarian functions, not least of which are the positive and restorative effects they have on the body. Laughter, for example, may have been an adaptive substitution for aggression, eventually becoming pleasurable and desirable in its own right. Biological evidence does point to laughter being a primitive response, evident in non-human animals such as primates, rats and possibly dogs. The human humour response needs also to be seen in social and psychological contexts reflecting more recent evolutionary components.

- **Superiority theories** explain humour as arising from seeing oneself as superior to, or less disadvantaged than, the person laughed at or about. Many of these theories view humour as stimulated by feelings of superiority not only in obvious cases involving mockery or ridicule but also where the humour is meant to be sympathetic or cordial. The point being that we are left with a favourable sense of "eminency", to use Hobbes' term, in response to the disadvantage of another. This can also arise from relief of not being in the shoes of the butt of the joke. The limitation of superiority theories is that not every situation

experienced as funny involves this characteristic and, likewise, many situations arousing feelings of superiority are not humorous.

- **Incongruity theories**, introduced by Keith-Spiegel with the description:

  Humour arising from disjointed, ill-suited pairings of ideas or situations or presentations of ideas or situations that are divergent from habitual customs form the bases of incongruity theories (p. 7).

  The role of incongruity in humour, and absurdity in general, is seen as critical by most humour researchers and practitioners. There is debate as to whether the humour response arises from the resolution of incongruity or simply with the experience of incongruity, irrespective of resolution being achieved or not. Although incongruity might be a necessary factor for something to be experienced as humorous, it is not a sufficient factor. Explanations of humour must include other components that may even vary according to the kind of humour and context in which it is being experienced. Also, the presence of incongruity in an experience does not guarantee it will be found to be humorous. Incongruity can stimulate distress, fear or anger as well as mirth and laughter.

- **Surprise theories** hold the element of surprise or unexpectedness as an essential component of an experience for it to be humorous. This idea can be consistent with other theories, for example incongruity often involves surprise and surprise can create momentary tension but then relief as the situation is perceived as benign. Surprise is a common component of humorous situations, but not a universal one. Something can still be experienced as funny and produce laughter even when anticipated. Many people report still finding episodes of *Fawlty Towers* hilarious even after having seen them often. At the tenth viewing, Basil's escapades might conjure up feelings of superiority or trigger a release of tension, consistent with other theories of humour, but we know exactly what is coming next and are often laughing at the anticipation of it before it actually occurs.

- **Ambivalence theories** are similar to theories focusing on incongruity as stimulus for a humour response. Where they differ is that incongruity theories focus on the cognitive or

perceptual response to juxtaposed incongruous stimuli whereas ambivalence theories see the simultaneous experiencing of mixed, and often incompatible, emotions as the humour response itself.

- **Release and relief theories** consist of theories that give primacy to the physiological responses to humorous stimuli as the explanation of why we have humour responses in the first place. In other words, by seeing something as humorous and thereby laughing we release excess tension or nervous energy that provides us with physical and mental relief. As with the other theories, this group identifies a common but not universal component of the humour response. Though laughter does tend to release tension, it might not always do so and, in addition, it can occur while a person is relaxed as can also the experience of something as humorous.

- **Configurational theories** are similar to incongruity theories but emphasise the resolution of incongruity, rather than simply the experience of it, as the trigger for a humour response. The resolution itself may still be incongruous, but the humour arises from being able to see and appreciate this. As stated earlier under incongruity theories, this difference can be seen to exist within that category and reference is sometimes made in the literature to 'incongruity-resolution theories'.

- **Psychoanalytic theory** is listed separately by Keith-Spiegel but could really be included above as a release or relief theory. The special element to these theories, derived from Freudian theory, is that humour is one means of re-channelling repressed and socially unacceptable emotions.

Although each may have a slightly different focus, four of Keith-Spiegel's groupings still have the experience of incongruity as their common theme and, as such, it is simpler to group them under a general heading of 'incongruity theories'. Lefcourt and Martin (1986) were of this opinion and preferred a simpler classification system than Keith-Spiegel's. Their three groupings were arousal theories that emphasise affective components of the humour experience; incongruity theories with more of a cognitive focus; and superiority theories. In a manner

similar to Lefcourt and Martin, I have settled on a simple classification of three groups in which I have also included a couple of contemporary ideas about the role of humour. I present this simple classification with the reminder that 'humour' is one of those concepts not amenable to a simple definition.

Arousal/relief theories:
biological/instinct/evolutionary; arousal; release/relief (including psychoanalytic); laughter as displacement.

Interpersonal theories:
superiority; group cohesion; liberation.

Incongruity theories:
Incongruity/incongruity-resolution/configurational; ambivalence; surprise.

Humour is indefinable and hence beyond theories

Suggesting alternative ways to classify theories or types of humour is made the more difficult by the indefinable nature of the concept and theories of humour are thereby compromised by this. There is a range of human experience for which words such as "humorous", "funny", "amusement" and "comical" all fall short as descriptions. This is not so much a limitation of the words but the complexity and indefinableness of the experiences. Limitations in defining and pinning down what is comical or humorous probably does render problematic the use of terms such as "experience of the comical", "experience of humour" and "sense of humour". Nonetheless, humour, the funny and the comical, the enchanting, and the unresolvable, though perhaps not justifiably nouns representing 'things' as such, do refer to real and often profound human experiences. The humour response involves a very real experience but this response/experience is diverse and complex.

The diversity of theories reflects the diversity of the concept and the range of experiences conceptualised. Any of these theories can be used to explain aspects of the experience of humour

but none are sufficient as a unifying explanation. The most favoured approach to an explanation involves the experience of incongruity, whether cognitively resolved or not, but not all encounters with incongruity are experienced as comical, some can even be terrifying, and the humour response can occur without incongruity. People can have many different reactions to others' disadvantage, such as relief without humour, sympathy or anger, and many situations found to be humorous do not involve someone being disadvantaged. The humour response can be quiet, involving a slight smile, without significant emotional and physiological release. The conclusion, at this stage at least, has to be that 'humour' is a complex phenomenon or concept that cannot be tied down to any specific explanation or category of theory. Every experience of humour, or at least most experiences of humour, involves one or more of the characteristics represented by the above theories but no single theory, thus far, encapsulates all experiences of humour.

What is meant by the statement "that joke was funny"? When something is referred to as "funny", the focus is usually on the physiological response to it, probably laughter, but also on the person's experience of the joke, notably its incongruity, perhaps resolution of that incongruity, and sometimes a sense of relief through feeling superior to the butt of the joke. Scientific approaches to the study of humour tend to be confined to measurable and easily definable aspects, especially behavioural indicators such as laughter as it is a physiological activity that is not, at least significantly, modified by sociocultural influence. On the other hand what is found humorous, funny, amusing and comical is very much socioculturally-bound. Human experience is mostly very personal and difficult to compare between people, even people within the same culture.

What is the most important aspect of absurdity? Is it the actual experience of something comical or perplexing? Is it the appreciation or resolution arising from that experience? Or is it the associated physiological release, such as laughter or dissipation of tension? There is a physical reaction such as laughter, or cognitive shift such as an "aha", in response to a resolution of paradox or other type of incongruity and both of these events normally have an emotional component that can be powerful. An interesting psychological research project would be to look at the experiential component of this process, including the emotions, but this is the most

difficult for science-reason, which is much more at home measuring behavioural and physiological responses to humour or possible measurable immunological effects. Most science-based research into humour, and other forms of absurdity, is limited in this way and incapable of throwing light onto how they are experienced and what it is about them that influences people to change.

ABSURDITY SCHEMA

The term 'absurdity' is a broad one representing several activities including paradox, humour, the comical, nonsense, irony, satire, parody, burlesque, playing the fool. Definitions of absurdity reveal several aspects of the concept. The following terms are taken from the Oxford and Macquarie Dictionaries and the Encyclopaedia Britannica.

Multiple realities:

- no single 'truth' or 'reality' should be considered as self-evident;
- 'common sense' is not truth or reality and there are many 'uncommon sense' alternatives;
- the universe is a place of multiplicity, complexity and chaos rather than regularity, commonality and order.

Nonlinearity, incongruities, paradox

- seemingly contradictory notions can co-exist as 'truths';
- contradictions can occur simultaneously.

Unreasonable, impropriety, abnormal

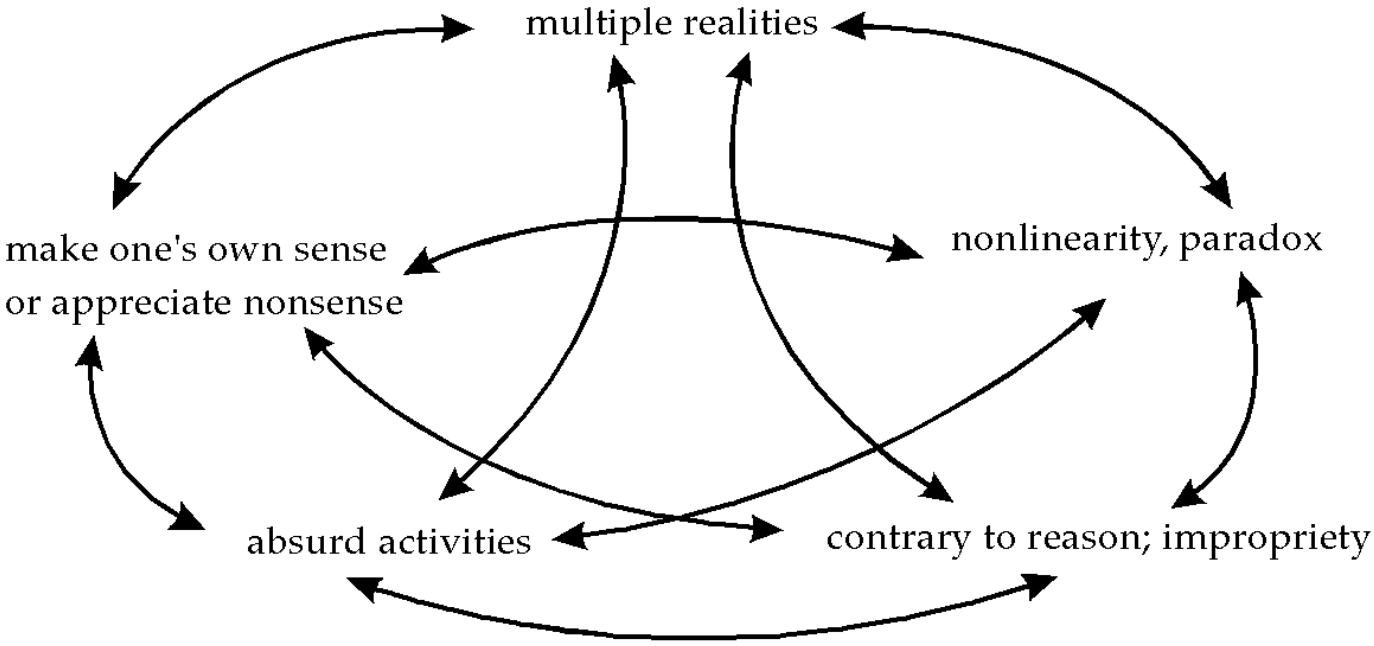
- **c**ontrary to reason or propriety;
- contrary to 'common sense', received opinion, established truths

Make one's own sense or appreciate nonsense

- leaves people to 'make their own sense' or (more profoundly) to learn how to tolerate, even appreciate and enjoy, unpredictability, incongruities and paradoxes;

- can be startling juxtaposition, fantastic, implication of marvellous and incredible or via subtle and continuous shifts, as in literature, especially poetry;
- arrests attention and provokes fresh thought;
- short circuits habitual and lineal thinking and provokes innovatory processes and perspectives;
- absurdity is spontaneous and emotional.

These characteristics can be depicted diagrammatically. All points of this schema are connected and any one can lead straight into any other one.



LIMITATIONS OF REASON AND LIBERATION OF ABSURDITY

Reason is a means of persuasion, convincing force, and control. Although absurdity can be a means of influence, it is unlikely to become overt persuasion. It is possible, however, for absurdity to be used as a means of control though these occasions could be reason masquerading as absurdity. Characteristics of absurdity, such as playfulness, spontaneity, and promoting flexibility are inconsistent with persuasion and control.

Reason as control is meant to keep things essentially the same or when change does occur it should do so only within the bounds set by reason. Order prevails, there are rules to respect, and any change initiated should be consistent and predictable. Absurdity is, by definition, incongruous with keeping things the same. Anything is possible and change through absurdity will be unpredictable and possibly inexplicable. When absurdity stimulates profound change, it is often highly charged with emotion and passion. Reason looks upon emotion with suspicion, even hostility.

If reason is a means to impose standards of normality and mediocrity whereas absurdity is a vehicle for going beyond them, perhaps with passion, is absurdity potentially a form of liberation, such as from constrained thinking or norms of behaviour? Reason starts with existing beliefs, considered to be facts or self-evident truths, and argues from them consistently and linearly. By definition it can only lead to outcomes that are consistent with existing beliefs and not greatly less or more than might be expected, within the boundaries of normality and mediocrity. The mode of argument of reason is defined as a "convincing force" to persuade others of its correctness and superiority and that it represents sanity. In total contrast, absurdity contradicts preconceived notions of what is reasonable or possible and, often surprisingly, flips people into outcomes beyond preconceived notions of what was possible, some of which may not be considered 'sane' from the perspective of reason.

Reason is a closed system, operating with set limits, and it ensures its own survival by determining all alternative means to knowledge to be inferior, invalid or insane. This has become the dominant operational model in most professional and academic arenas, very much so in psychiatry and psychology, and less so, though still extensive, in psychotherapy. This dominant model frames sanity as consistent with reason, and insanity as inconsistent, incongruent, and at odds with reason. Insanity has become a garbage-can label, as have many of the supposedly specific diagnostic categories subsumed under psychiatry, referring to clinical states but also groups of behaviour labelled inappropriate or abnormal. These are issues pointing to a discussion about psychiatric diagnosis and treatment beyond the scope of this thesis.

Can absurdity be a means to liberation and, if it can, what kind of liberation would this be? I have discussed earlier how reason left to its own devices can lead to extremely unreasonable, perhaps insane, consequences. Presumably the total overthrow of reason, and along with it science, is neither possible nor desirable. Though I may be falling prey to the delusion of reason, this does appear to be a recipe for madness. Perhaps becoming perpetually absurd, allowing no space for reason, would lead to insanity and conversely being always governed by reason, having no time or tolerance for absurdity, could also be a form of insanity. Do reason and absurdity need each other as, without the other, either can lead to madness and self-destruction?

One way in which absurdity is a form of liberation is that it frees people from the dangers of unrestrained reason. It is reason, not reality, that absurdity can liberate people from. That is to say, it is liberation from personal realities arising out of reasoning rather than some objective external reality. This may be liberation from seriousness and predictability through flexibility, playfulness and spontaneity. It may be liberation from conformity and the demands of so-called 'common sense' through impulsivity or eccentricity. It may be liberation from authority and control through satire and ridicule. It may even be liberation from oneself through laughing at one's inadequacies or mistakes. Though temporary in its immediate effect, this liberation through shifts in perspective and behaviour towards personal realities can produce enduring changes in those personal realities. People learn to see things in a different light and respond to them in different ways. Mindess refers to this shift in perspective as the attainment of a "god's-eye view", using D. H. Monro's phrase (reference in Mindess (1971, p. 30), a concept similar to those of 'nonattachment' and 'the witness' in Buddhist meditation.

> At times of personal distress and, equally, at times of national tragedy and international horror (which, I guess, means pretty much all the time nowadays), this attainment is invaluable. It may not enable us to change reality, but it enables us to endure it. It may not allow us to discard our egos, but it allows us to transcend them. The full development of our sense of humor results in a frame of mind so free, so flexible, and so kaleidoscopic that it rigidifies nowhere, gets hooked on nothing. It results in a frame of mind so bold that it finds no creature and no institution sacred; a frame of mind so subtle that it discerns the irony that runs through all human affairs; a frame of mind so candid that it comprehends the hypocrisy of its candor; a frame of mind so indifferent that it has no more need of pride. It is this frame of mind that can, with some conviction, be called our ultimate hope, for the ability to evoke it represents an ability to take whatever comes with a shrug if not a smile (Mindess, 1971, p. 30).

Perhaps reason and absurdity can simultaneously be antithetical and yet co-exist, a paradox intolerable to reason but intriguing from the perspective of the absurd. The three relationship modes between absurdity and reason presented early in this chapter, absurdity as inferior, equal, or superior to reason, might all apply at different times and for different reasons. Reason has produced many benefits and useful forms of knowledge. Individual lives and social contexts function by reason's rules and, in many cases though not all, would collapse if they did not do so. Mindess (1971) describes how absurdity and spontaneity can liberate people from conformity but points to the benefits gained from reason as inevitably bringing them back from absurdity.

> Contrary to the claims of radical dreamers, we experience not just a diminution of ourselves in our conventional routines but, paradoxically, an enhancement too. In relinquishing the random play of impulse, we acquire skills and knowledge, and all the cynicism in the world cannot deny the satisfaction to be gleaned from such accomplishment. All pleas for spontaneity notwithstanding, it is futile to disclaim the pleasure of learning to play the piano, mastering the potter's wheel, or comprehending the strategies of chess – yet the achievement of these ends inevitably demands the surrender of our whims to a regime of concentrated effort (pp. 39-40).

The conclusion drawn from this should not be the confirmation of reason's superiority, but that reason and absurdity can be considered equal with each useful in very different ways and appropriate in different contexts, sometimes existing separately, sometimes alternating, and paradoxically sometimes occurring simultaneously. The danger lies in absorption in one mode only. This has mostly occurred as absorption in reason and seriousness and blindness to the liberating and passionate influence of absurdity and laughter. The challenge is for people to allow themselves to be more absurd and spontaneous, to be more playfully idiotic, poke fun at themselves and fool about in, and with, their social contexts, including work contexts. This is not a simple matter however as seriousness and reasonableness become entrenched as ways of behaving and thinking and are thoroughly socially reinforced.

The challenge for psychotherapists is to find ways to become less serious and more playful, at least some of the time, to find and develop their sense of humour, and to be more flexible in how they work with clients, especially in terms of power and control. The obstacle to therapists

taking up this challenge is the dominance of reason as psychotherapeutic orthodoxy and consequent rejection of absurdity as an acceptable approach to therapy. Although absurdity appears to have been gaining ground recently, especially over the last couple of decades, it is still a rarity in university psychology courses and mostly considered as fringe or an adjunct to the real, serious work of therapy. The irony is that therapists will often identify the ability to be spontaneous as an appropriate therapeutic outcome without understanding that reason will not get them there, only absurdity will. How to become more humorous, playful, flexible, spontaneous and absurd cannot simply be taught or shown. They can only be learned and experienced. Most counsellors and therapists are trained and paid in environments dominated by reason, seriousness, and accountability according to orthodox criteria. It takes a leap of faith to venture into the world of absurdity and the comic.

CHAPTER 3: WHAT IS PSYCHOTHERAPY?

HISTORY OF PSYCHOTHERAPY

Before discussing the emergence of psychotherapy from its origins in medicine in the late 19th century, I would like to comment briefly on the similarity between modern psychotherapy and ancient roles of healer and facilitator of change. Though perhaps rather simplistic, some parallels can be drawn between the role of the psychotherapist in contemporary society and that of the 'medicine man', shaman or witch doctor in traditional societies, particularly in terms of people seeking relief from suffering from a specific person who has been credited by their social group as possessing special powers or skills for this task. There are, of course, risks or limitations in making this comparison, a couple of which can be noted here.

Traditional healers often had broader and grander roles than do modern psychotherapists, such as being priest, sage, mystic, medicine man, tribal chief or, often, a combination of some of these roles. Having said this, as has been achieved by medicine in general, some psychotherapies and individual psychotherapists manage to generate some grandiosity within their own sociocultural contexts. This was particularly evident with traditional psychoanalysis and is relevant to the discussion on power in this thesis. Therapists can also create an aura of mystery and the magical through certain techniques presented as producing change, sometimes profound, by means difficult to explain in the usual ways. Hypnosis can be experienced in this way although various rationales for its effect have been suggested. The various 'energy therapies' and 'emotional freedom therapies', that are claimed to free energy flows through body and mind, for example by tapping acupuncture points while imagining a disturbing scenario, can also produce a sense of the mysterious and profound.

Another risk is that general comparisons and use of a generic concept such as 'traditional healer' minimises an enormous diversity of roles throughout different cultures and ages. Nevertheless, a common theme is that each culture, traditional and modern, identifies a particular role as potentially providing members of that society relief from physical, psychological or spiritual suffering. The person in that role is credited with capabilities in the relief of suffering that other

people do not have, capabilities that arise from a higher source, such as communion with gods or from professional training, and are given credibility by esteemed levels of explanation, such as religion, magic, or science. Although different contemporary psychotherapies reflect a range of explanations and paradigms, some of which may be viewed as more akin to religious or spiritual themes, and some more as artistic expressions rather than scientific, psychotherapy as a defined practice has its origins in medicine, and psychotherapeutic orthodoxy has been steeped in a science-medical model ever since. The question of whether psychology is art, religion or science is returned to later in this chapter.

During the second half of the 18th century, Austrian physician Franz Anton Mesmer gained fame and glory initially, but condemnation and ostracism by the medical authorities eventually, for his elaborate and somewhat mystical method of treatment he named 'animal magnetism'. Mesmer's explanation of how his treatment worked was based on planetary influences, an invisible bodily fluid and the channelling of magnetic force from a healer to a patient. The actual therapeutic mechanisms leading to symptom relief were probably the induction of a trance state and consequent heightened suggestibility, two key aspects of hypnosis and many traditional approaches to healing.

Despite the 'spiritual' implications of his theory, Mesmer considered his approach to be consistent with science, at least science as it was portrayed at the time, and based on a secular view of the world. As Mesmerism is often presented as the forerunner of modern secular psychotherapy (Cushman, 1997, pp. 30-32) perhaps the contrasting interpretations of it as secular science or spiritual artistry can be seen as the forerunner of the same equivocalness about modern psychotherapies. Cushman puts this into the context of the growth of Mesmerism in the United States during the mid-18th century.

Mesmerism and its heirs emphasized alternative states of consciousness, exotica, American naivete and optimism, and a secular, anti-intellectual spiritualism.

However, mesmerism also claimed to be a scientific technology. By solving a spiritual problem through science, it revealed itself to be quintessentially Victorian. Mesmerism, and especially its heirs, also foreshadowed many 20th century forms of psychotherapy and contemporary restrictive groups such as religious cults, mass marathon

psychology trainings, and New Age experiential programs. Seen in this light, mesmerism was simply the first in a long line of attempts to heal the psychological problems, spiritual hunger, and moral confusion of the American unchurched (1997, p. 31).

In 1843, the British surgeon James Braid became interested in the therapeutic and pain management potential of Mesmer's method though rejected Mesmer's theory of how it worked. Braid looked to what he saw to be proper science rather than Mesmer's 'false' science for an explanation and developed an essentially neurophysiological theory, based on experimentation and observation, that nervous energy could be used to lead to a sleep-like trance state in which people could respond to suggestions of, for example, anaesthesia. For this technique and state, he came up with the term "hypnotism" (Braid, 1843), from the Greek word for sleep, 'hypnos', later to be renamed by the Dutch physician van Eeden as "suggestive psychotherapy".

The concept 'psychotherapy' is less than one hundred and fifty years old. In 1872, Daniel Hack Tuke introduced his original word 'psychotherapeutics', defining it as:

… phenomena involving restorative processes which justify the employment of (in addition to physical remedies) a reasonable psychopathy, or Psychotherapeutics – a preferable term in an age when the multiplication of *pathies* is undesirable (1872, p. 418).

Two decades later, in his *Dictionary of Psychological Medicine*, Tuke (1892) defined the by then more accepted word 'psychotherapy' as: "the treatment of disease by the influence of the mind on the body". By the time of the first congress on psychotherapy, held in 1894 in London, 'psychotherapy' had become the conventional term for the medical use of psychological treatment. These beginnings of the modern concept of psychotherapy were occurring in tandem with the early stages of institutionalising psychology as an academic discipline with allegiance to science rather than philosophy as had previously been the case. The first meeting of what would become the American Psychological Association was held at Clark University in 1892. In *The Principles of Psychology*, published in 1890 and one of psychology's classic texts, the functionalist philosopher William James states in the first sentence, "Psychology is the science of mental life". Functionalism was a major influence subsequently leading to behaviourism. The person usually credited as the founder of scientific, empirical psychology is Wilhelm Wundt

who in 1879 opened the first laboratory for the research and teaching of psychology and in 1881 began publishing *Philosophische Studien*, the first journal concerned with experimental and observational research.

At about the same time Sigmund Freud was beginning his medical career and by the mid-1880s had opened his first consulting rooms in Vienna. His background was firmly based in 19th century medical science, specifically physiology and neuropathology, but his move from research to clinical practice shifted his emphasis to the treatment of psychological problems, leading eventually to what became known as psychoanalysis. Psychotherapy came into being as a treatment modality of scientific medicine, developed by physicians primarily to aid in the treatment of physical disease and many of the assumptions and behaviours operating under the general concept of psychotherapy today can be seen to reflect its birth from science and medicine. The word 'therapy' is a concept of scientific medicine referring to the treatment of illness as defined in the Macquarie Dictionary: "the treatment of disease, disorder, defect, etc., as by some remedial or curative process." Although Freud represented a new emphasis on the 'mental', his work remained within a medical and biological framework. The emergence of behaviourism as the new orthodoxy to replace psychoanalysis represented the entrenchment of psychology, and subsequently therapy, into much stricter criteria of science. This continues today with the insistence by professional and academic psychology institutions that psychology is a science and cognitive behaviour therapy (CBT) is the accepted application of scientific psychology into treatment.

When restricted by a science-based and medical model, the term 'psychotherapy' may be seen as inadequate or even misleading as it excludes non-medical reasons and contexts in which activities referred to as psychotherapies occur. There have been periods and models of therapeutic change that have moved away from, even challenged at times, the science-medicine paradigm underlying conventional psychotherapy, such as some of the humanistic-existentialist, transpersonal, feminist and radical approaches. The shift of focus away from negative symptoms onto personal growth that developed in the 1960s, particularly through the influence of existentialism and the development of humanistic psychology, suggested an alternative

paradigm for psychology and psychotherapy, stimulating much criticism from the scientific psychology and psychiatric orthodoxies.

> The question of controlled studies or statistical evaluation of results is all but brushed aside. The quantitative approach seems to run counter to the spirit of the existential method itself. Yet if this is true, we have to realize that the existential therapist has virtually excluded himself from the mainstream of modern psychiatric research and treatment. Despite his protestations, the gap between his and the scientist's "modes of existence" remains open. They do not have a *koinos cosmos* – a common world – to share, and their dialogue is hampered by the different levels of discourse upon which they are poised (Ehrenwald, 1966, pp. 102-103).

The drive in science for commonality, reflected in this quote, is discussed later in this chapter. The assumption that leaving the confines of the scientific model will condemn psychology and psychotherapy to peripheral irrelevance is echoed in the following *Lancet* editorial comment.

> … psychotherapy will doubtless survive but will drift even more into the fringes of medicine, an option only for those who are prepared to pay and ask no questions about outcome (cited in Haldipur, C. V., 1985, p. 732).

In fact, the early advocates of humanistic psychology, such as Abraham Maslow and Carl Rogers, did not see themselves as rejecting science but as including a wider range of human characteristics to be studied scientifically than had been allowed by behaviourism and shifting the focus of study from behaviour to human experience. In therapy, this meant a shift in focus from behavioural change to experience of self, especially in relation to others including the therapist. Freeing therapy from the extremely narrow focus of behaviourism began the proliferation of therapeutic approaches and eclecticism that continues today despite the survival of a science-CBT psychotherapeutic orthodoxy. More detailed discussions of the major psychotherapy models can be found in the next chapter.

WHAT IS PSYCHOTHERAPY?

Most discussion in the psychotherapy literature has been about the efficacy of therapy in general; efficacy of therapy in comparison with other modes of treatment, such as medication; comparisons between different models of therapy; descriptions of specific models of therapy; or

discussions of specific psychotherapy techniques. The first three groupings are mostly concerned with whether psychotherapies are effective and, if so, what makes them effective and what are they effective in doing. Results vary considerably. Conclusions from efficacy studies range from psychotherapy being no more effective than placebo, more effective than placebo when done in conjunction with other treatments such as medication, to some therapies being more effective than others. Comparisons have mostly been between CBT and non-psychological treatment modes or CBT and a limited range of other psychotherapies, particularly psychoanalytic or psychodynamic approaches. The limited range of studies reflects quite entrenched orthodoxies in psychotherapy that only CBT and established, mostly psychodynamic, approaches should be given any legitimacy by the professional bodies of psychology and medicine, in particular psychiatry, in university training, and in provision of health funding.

Along with discussions of efficacy, the other most common publications on psychotherapy are about specific psychotherapeutic models and techniques. Most presentations and descriptions of specific models are to be found in edited texts (e.g. Corsini, 1980, 1981; Wolman, 1983; Palmer & Woolfe, 1999) and in books written by founders of specific therapies or by their professional students. These accounts will often provide historical and theoretical backgrounds to the development of the model as well as presentations of cases and discussion of how to work with the model. There are also texts describing a particular approach to therapy, and techniques used within that approach, that are more or less therapist how-to-do manuals. This kind of manual is only feasible for a therapy model that can be broken down into step-by-step methodologies, such as behaviourist and cognitive-behavioural. Finally, there are various publications presenting a specific psychotherapeutic technique, such as hypnosis, working with dreams, therapeutic metaphor, and role-playing, that may be found in more than one psychotherapy model.

Numerous histories of psychotherapy in general can be found in the literature, some of which are referred to in this thesis, though, as Cushman (1997) points out, historical presentations tend to clump the diversity of psychotherapies into a generalised category insensitive to the range of philosophical and sociocultural variations that typify the field.

The most common way historians of psychotherapy celebrate rather than critically interpret their subject is by decontextualising it. In other words, by failing to situate the various theories and practices of psychotherapy within the larger history and culture of their respective eras, some historians treat psychotherapy as though it were a transhistorical science that treats universal illnesses. These historians imply that because psychotherapy is a science, its findings are akin to facts and that because it is a transhistorical technology, its practices are apolitical. (p. 23)

The assumptions underlying, or implied by, the decontextualisation of psychotherapy present the array of practices and relationships that constitute it as essentially similar and that they are always intended to be curative of emotional or behavioural illness, suffering, dysfunction, or disorder. To a degree this is unavoidable given the enormity of the subject and, despite pointing this out, this thesis at times has to fall into the same trap, as when attempting to formulate a definition and when discussing specific approaches or types of intervention such as humour and paradox. The decontextualising of psychotherapy tends to arise from, and lead to, discussions of psychotherapy being limited mostly to the topics listed above, efficacy, comparisons, models, techniques and historical accounts. Issues not often discussed in the psychotherapy literature include:

- sociocultural contexts and influences;
- power issues in the therapist-client relationship and within the profession;
- the political aspects and economic determinants of therapy;
- the 'goals' of psychotherapies, such as whether they are vehicles for adjustment to 'normality' or for liberation or noncomformism.

These topics are more reflective of a social constructivist, rather than positivist, discussion of therapy, psychological difficulties and processes of change and focus more on sociocultural contexts of therapy than the structures of therapy. From a social constructivist perspective the various issues in both of the above lists influence, arise from, and modify one another. This is an interplay and richness impossible to encapsulate in definitions and classifications. As Cushman goes on to suggest:

… psychotherapy theory and practice are social artefacts and as such both reflect and shape the configuration of the self and the illnesses of their era. Artifacts such as political institutions, psychotherapy theories, and common

psychiatric illnesses fit together. They are not direct, conscious conspiracies; they are the interactive forces that mutually influence one another (1997, p. 34).

Defining Psychotherapy

Many general concepts are difficult to pin down to a simple definition without sacrificing much of what the concept represents. Examples of this include the concepts of love, hate, beauty, spirituality, humour, community, society and self. Numerous types of human endeavour are similarly difficult to pin down to a precise definition due to the complexity or diversity included within the label. The concept and role of the 'healer' in a society is one of these as it is a socioculturally defined role mediated by a range of beliefs, such as about health and illness, normality and abnormality, safety and threat. Although science-driven orthodoxies in psychology and psychotherapy push for homogeneous definitions and structures of practice, these are actually activities that defy tight classification. This is not to say that attempts at definition and general classification cannot be useful, indeed I will be offering a qualified attempt while acknowledging the limitations inherent in doing so. Definitions and classifications of complex issues are inevitably artificial in some way but can be useful as communication tools as long as they are not misinterpreted as 'reality' in themselves. As Alfred Korzybski put it, "the map is not the territory" (1973, p. 38).

Two basic definitions of psychotherapy were included recently in *Australian Psychologist*, a professional journal of the Australian Psychological Society.

…an interpersonal process designed to bring about modifications of feelings, cognitions, attitudes and behaviour which have proved troublesome to the person seeking help from a trained professional (Strupp, 1976, cited in Charman, 2003, p.42).

…a planned, emotionally charged confiding interaction between a trained socially sanctioned healer and a sufferer. (Frank, 1982, cited in Charman, 2003, p.42)

These are very general attempts at defining an activity and relationship that has become enormously diverse since the early formulations by Tuke and Freud. Even by 1980, in the

Introduction to the 3rd edition of his book *Current Psychotherapies*, a comprehensive presentation of psychotherapies in existence at the time, Corsini warns that a precise definition of psychotherapy, "a truly bewildering set of ideas and behaviours" (p. 1), is no longer feasible. After presenting numerous "bewildering" examples he adds:

> All these and many other strange and wonderful concepts and procedures have been employed in that which is called psychotherapy. It is important to note that what some authority considers to be psychotherapy may be completely different from how another person sees the process (p. 1).

The "bewildering" plethora of activities called psychotherapy has continued to grow since Corsini's 1980 warning against attempting a universal definition and there are now over four hundred recognised contemporary models or systems of psychotherapy. In light of such a plethora of psychotherapies and underlying assumptions about human processes, the nature of change and approaches and methods employed, any attempt to define psychotherapy might appear futile. Also, as mentioned earlier in this chapter, general definitions or portrayals of psychotherapy risk decontextualising psychotherapy, artificially extracting the activity from its sociocultural contexts and ignoring many of the less conspicuous approaches. Nonetheless, in the spirit of reductionism, a basic attempt at a definition will be made here keeping in mind that any attempt at a general definition of a complex phenomenon will inevitably fall short and can always be challenged.

In his classic text on psychotherapy, *The Technique of Psychotherapy* (1988), Wolberg at the outset offers this definition:

> Psychotherapy is the treatment, by psychological means, of problems of an emotional nature in which a trained person deliberately establishes a professional relationship with the patient with the object of (1) removing, modifying, or retarding existing symptoms, (2) mediating disturbed patterns of behaviour, and (3) promoting positive personality growth and development (1982, p. 3).

Wolberg observes that the process of psychotherapy includes a wide range of behaviours involving "adequate communication, verbal and nonverbal", though he acknowledges this to be

a criterion that disqualifies some approaches to therapy such as psychodrama and dance therapy.

> The sundry published definitions of psychotherapy agree on one point – namely, that psychotherapy constitutes a form of approach to many problems of an emotional nature. They do not agree on other aspects, such as the techniques employed, the processes included, the goals approximated, or the personnel involved (1988, p. 10).

Wolberg analysed the various attempts he could find to define psychotherapy that had made up to the time of writing *The Technique of Psychotherapy*, from which he concluded the only point they had in common was a focus on dealing with "problems of an emotional nature". He gleaned from the literature thirty-nine examples of definitions or components of definitions and recorded them in his book (1988, pp. 10-14). Here are some of them:

- Psychotherapy is … a developing transaction between two people, one *suffering from some type of distress or exhibiting disordered behaviour*, the other offering amelioration as part of his professional activity.
- [Psychotherapy consists of] *techniques derived from established psychological principles, by persons qualified through training and experience to understand these principles and to apply these techniques* with the intention of assisting individuals to modify such personal characteristics as feelings, values, attitudes, and behaviours judged to be *maladaptive* or *maladjustive*.
- [Psychotherapy endeavours] to *alter the behaviour and change the attitudes of a maladjusted person* toward a more constructive outcome.
- Psychotherapy is a form of *treatment in psychiatry* in which the psychiatrist, by his *scientific thinking and understanding*, *attempts to change* the thinking and feeling of people who are suffering from *distorted* mental or emotional processes.
- Psychotherapy is a *planned and systematic application of psychological facts and theories* to the alleviation of a large variety of human *ailments and disturbances*, particularly those of psychogenic origin.
- [Psychotherapy] connotes the *use of definitive psychological techniques* designed to relieve *demonstrable disturbances* in psycho-social *adjustment*.

- In its classic sense, psychotherapy is defined as the *restructuring of the malfunctioning personality*.

The italics are mine to emphasise the recurrent themes that appear in most of the definitions recorded by Wolberg, these being the science-medical model; disorder and maladjustment; and the expert-power status of the psychotherapist. Interestingly, the third definition above was by Carl Rogers, one of the founders of humanistic psychology, the creator of client-centred therapy and significant influence on the human potential movement. Only half a dozen of the thirty-nine definitions manage to stay away from, or at least minimise, these themes, most notably:

- [Psychotherapy is] an emotional exchange (process) in an interpersonal relationship which accelerates the growth of one or both participants.
- Psychotherapy is … a co-operative enterprise for clarifying purposes and modifying attitudes in the direction of greater integrity of personality.
- Psychotherapy is a certain kind of social relationship between two persons who hold periodic conversations in pursuit of certain goals: namely, the lessening of emotional discomfort and the alteration of various other aspects of client behaviour.

The first of these three definitions does not imply any of the themes of science-medicine, maladjustment or therapist's higher status. On the contrary it implies a personal relationship based on equality and a focus on personal growth rather than adjustment. This definition was by Carl Whitaker, a famous therapist who would introduce nonrationality and humour into his therapy sessions and who is referred to and quoted elsewhere in my discussions of absurdity.

Perhaps it would be more realistic to settle for multiple definitions of groups of therapy based on similar theoretical models or types of procedures as no one definition can accommodate all systems, models, theories, practices and procedures referred to as 'psychotherapy'. At best, a skeletal definition can be formulated based on the essential components of the interaction referred to as psychotherapy, as follows:

- Psychotherapy is a process of interaction that may be formalised (mutually defined as psychotherapy) between two parties. Each party often, but not always, consists of one person though party #1 can consist of a single therapist or co-therapists and party #2 can be an individual, a couple, a family, or a group, usually referred to as the 'client' or 'patient'.

- Party #1 normally has some sort of professional/legal sanction/status arising from having training/experience in at least one particular system of procedures (methodology, techniques, strategies, operations, 'technologies') that are normally seen to have a rational basis, whether explicitly stated or implied, in some theory of personality and/or theory of communication and/or theory of change.

- Party #2 will usually, though not always, be voluntarily seeking assistance from party #1. Although party #2 is often the person who approaches party #1 initially for assistance, this is not always the case. Who requests therapy for party #2, and for what reasons, can be a significant influence on the therapeutic relationship and party #2's response to therapy. People requesting therapy, other than the actual client, include family members, health professionals, employers, schools and legal professionals.

- There is normally an expectation that party #1 applies their system of procedures to produce (directly or indirectly) some sort of change in party #2, usually either to reduce a problem or suffering or to enhance an ability or sense of wellbeing.

COMMONALITIES AND DIFFERENCES BETWEEN DIFFERENT MODELS: WHAT THE PSYCHOTHERAPIES (ARE SUPPOSED TO) DO

There is not only disagreement and confusion about what psychotherapy is but also what it does or what is claimed that it does. There is general agreement that some kind of change, at least for party #2, is a desirable goal of therapy but there are differences as to what kind of change this should be and how it is to be brought about. Several questions arise from this. What issues do

different therapists guide their clients to focus on? In other words what role do therapists play in influencing what clients end up focusing on in therapy? What do different therapists see the point of therapy being and what do they consider can be the overall potential for therapy? For example, is therapy mainly a process aiming for adjustment and normalisation or is it potentially a means to profound change and even liberation? How do different therapists see their role in relation to clients and how do these views affect the power dynamics between therapist and client? These are important questions not just confined to attitudes of individual therapists but represented by the various models of psychotherapy influencing most of those therapists.

While putting together a compilation of psychotherapies, for which various therapists were invited to write a chapter about their model of therapy, Corsini (1981) attempted to classify the therapies according to various criteria, such as client control, time orientation, whether principally focused on behaviour, cognition or emotion, and so on. There was so much disagreement amongst contributing authors on what could constitute useful means of classification of their therapies that Corsini abandoned his attempt to do so. He does, however, point out that his intended classification criteria, as listed below, reveal considerable differences between the psychotherapies.

- *Control*: the degree to which therapy is client-centred or therapist-centred or a balance between both.
- *Awareness*: how much therapists work with clients' conscious material or see themselves working at subconscious levels.
- *Temporality*: whether therapy focuses mostly on past events, present experience or consideration of the future.
- *Range of results*: relating to the type and degree of outcome aimed for in therapy, ranging from limited, specific behavioural changes to major transformations in personality, self-concept and lifestyle.
- *Focus*: whether principally on behaviour, thought processes or feelings.

- *View of humans*: the underlying philosophical position on how much humans exercise freewill or are subjects of pre-determination, which also links to the debate on the causes of behaviour as heredity, environment, or self-directed.
- *Operations*: referring to how limited or broad is the range of activities, behaviours, strategies, methodologies available to the therapist. I would add to this the degree of flexibility available as opposed to rigid adherence to prescribed practice.

Although there may be some basic components that are similar across most approaches to psychotherapy, as formulated in the definition earlier, there are many more differences. These are not just differences in techniques but also in client-therapist relationship, including the role of implicit and explicit power, and view of what therapy is, in other words what it is meant to achieve. In his article *What is Psychotherapy? Back to Basics*, Melbourne clinical psychologist Ivan Milton describes the various roles he sees himself playing as therapist at different times and with different clients and how this reflects his therapy as different types of activity (1995, pp. 29-31). His range involves:

- therapy as guidance;
- therapy as support;
- therapy as transference, as he describes it, "the resolution of stuckness through the immediacy of the therapeutic relationship" (p. 29);
- therapy as catharsis, " the discharge of feelings with resultant changes in symptoms" (p. 30);
- therapy as confession in which therapists act as "witness" while clients are "unburdening" themselves;
- therapy as skill development, a role that, as Milton points out, is very popular with cognitive-behaviourists;
- therapy as discovery, referring to which Milton states "When I see my work as a stimulus to discovery I become less directive, I let go into being a collaborator rather than a leader" (p. 31).

It is interesting that for Milton therapy as discovery is the only mode that allows him to become "less directive". In fairness there is usually a degree of therapist directiveness in a therapy session, even if only to set the scene and 'get things going', but the extent and nature of this will vary considerably between therapists and different approaches to therapy. For example, whereas directiveness, and also directness, are characteristic of the role of reason as a mechanism of change they do not sit comfortably with absurdity. As will be seen in subsequent discussions absurdity in therapy tends to be nondirective and indirect as a mode of communication.

Milton's article arose from his desire to review his understanding of psychotherapy after having been practising it for fifteen years. He set himself two tasks: to revisit the basics of counselling and to review and possibly expand his conceptions of what psychotherapy is. I have often recommended to my psychotherapy supervisees, many of whom have worked in the field for years, at times to remind themselves of the basic principles and attitudes of counselling as a means to stay "grounded" when working with clients and remember that, more than anything, counselling and psychotherapy is about an intense and genuine relationship with a unique other person. Milton's basics of counselling are self-awareness, active listening, compassion, skilled questioning, genuineness, and Rogers' concept of "unconditional positive regard". These are attitudes and behaviours that should hold therapists back from becoming lost in their techniques or infatuated with power. He refers to the famous Gestalt therapist Erving Polster's point:

> …. that every technique pays a price, and we should keep constantly alert to the consequences of our techniques. He suggested that every intervention needed the 'right' quality of contact, and that in order to be up to date with our own methods we must be sufficiently up to date with the negative consequences of those methods (Milton, 1995, p. 27).

How do reason-based and absurdity-based approaches to therapy differ in how, and how well, therapists can keep themselves based in these ways of being with clients? My argument that reason is more likely to, perhaps will inevitably, create power imbalances between therapist and client would indicate some difference. I have acknowledged that absurdity can appear to have

the same potential, such as in the use of destructive humour, but also pose the question of this possibly being reason masquerading as absurdity. Similarly, if reason is a means to persuade or impose, however gently and caringly it may appear and even be intended, it would seem to be compromising of counselling basics such as genuineness and unconditional positive regard. This also brings up the issue of change and whether reason can help clients change in whatever way they may aim for or will ultimately hold them back from making profound changes that take them beyond the boundaries of their conventions.

Milton's list of types of therapy above is interesting in that it presents potentially different levels of therapy that may lead to different levels, and quality, of change. I see some of his types as counselling rather than psychotherapy as they operate on a superficial level aiming at fairly straightforward outcomes. This is not a comment to devalue counselling but an attempt to differentiate surface and deeper levels of work and skill needs of counsellors and psychotherapists. The two terms, counselling and psychotherapy, are sometimes used interchangeably but the degree of training, skill and ability to respond to crisis needed to support someone or guide them in attaining simple outcomes is different to working with profoundly disturbed people and strong cathartic releases of emotion. Having said this, it must be added that there are not clear boundaries between counselling and psychotherapy, for example a session that starts as simple support can develop into one of confession and catharsis.

Keeping in mind the qualification in the previous sentence, Milton's types can be divided into two groups based on level of operation. Therapy as guidance and therapy as support usually function at the more superficial level of conscious awareness and for straightforward reasons. Therapy as skill development and as discovery can also fall into this category depending on the kind of skill and nature of discovery aimed for. These activities involve mostly linear processing though the supportive role may not be attempting to achieve anything other than being supportive. The term 'supportive psychotherapy' is sometimes used but is normally referring to the same process as supportive counselling. Reason is usually a perfectly adequate means by which counsellors can function in these roles as long as they communicate well and allow clients to talk freely and come up with their own ideas. The question arises whether in this case clients can arrive at their own conclusions without having been influenced by the counsellor.

Therapy as skill development and as discovery can function at more profound levels than I would classify as counselling. Personal discovery, particularly, can be a dramatic and cathartic experience. My discussion of reason and absurdity portrays reason as ultimately limited in the nature of discovery it can facilitate as it will only bring about discoveries of the same essential nature as what the person already knows. This is, in any case, the nature of most events described as 'discoveries', and perhaps, as suggested in the stronger version of hypothesis #1, *all* discoveries arrived at through reason including, therefore, much of scientific discovery. It would be naïve to apply this to *all* outcomes of science as not all of them are arrived at purely through reason and scientific methodology. Science can lead to profound explanations beyond the nature of explanations preceding them but only if taken beyond the constraints of reason-science methodology, for example during paradigm shifts. This relates back to the differentiation between reason as definition and reason as process discussed earlier.

Therapy as transference, as catharsis, and as confession can be classified as types of psychotherapeutic process. It can be argued that transference occurs in counselling but it is more likely to emerge as the relationship, and material being dealt with in that relationship, deepens. Unlike 'catharsis' and 'confession', which refer to observable human activities, the term transference is a hypothetical construct used to explain displacement of feelings and attitudes of one person, in this case the 'client', onto another, in this case the 'therapist'. These feelings and attitudes are seen as displaced because they are really about another person, usually a close family member.

While considering Milton's reflection of his therapy as different types of activity, I decided to reflect on my own work and on psychotherapy in general and arrived at some more types.

- therapy as sounding board;
- therapy as problem solving;
- therapy as treatment;
- therapy as insight and self-awareness;

- therapy as making sense, for example of one's predicament, of relationships, of the world, and it may be a process of client and therapist co-creating a 'common sense';
- therapy as transformational experience;
- therapy as quality company, safe human contact, a place to be heard;
- therapy as relationship;
- therapy as existential encounter;
- therapy as (re-)parenting.

Two further types arose from my more cynical mind.

- therapy as mechanics, technology and technique;
- therapy as influence, persuasion or control.

For the sake of clarity, Milton's types and my types can be grouped into seven categories.

Therapy as achieving practical goals

- problem solving;
- skill development.

Therapy as support

- sounding board;
- guidance;
- supportive counselling/psychotherapy.

These two categories are types of counselling. Though the next category often appears as counselling, it represents a medical model of psychological and emotional needs and is explicitly based on the idea of therapy as treatment.

Therapy as treatment

- implying psychological difficulties are illness as opposed to health, concepts that warrant thorough discussion about their applicability to psychotherapy which, unfortunately, cannot be placed here.

The next three categories are types of psychotherapy, though relationship is normally also a key component of counselling.

Therapy as discovery

- Milton's explanation of his role in therapy as discovery, as discussed above, used the term "heuristic stimulus" to imply the need for him, as therapist, to be inventive and go beyond "programs and recipes" (and, I would add, techniques) as essential for clients to discover rather than simply reframe;
- development of self-awareness and insight are explicit goals of many therapies, particularly psychodynamic and humanistic, and not considered important, or at least not essential, by others, for example behaviourist, brief therapies, strategic approaches, and some of the more recent popular therapy models such as Eye Movement Desensitization and Reprocessing (EMDR) and the group of so-called 'energy therapies';
- people need to make sense of their experiences and it may be that a lot of what is interpreted as developing insight or discovering something new in therapy is no more than making some different sense of experiences, and replacing one sense with another does not necessarily constitute insight or discovery. In therapy, such as in Milton's collaborative role, this may simply be a case of therapist and client co-creating a new sense, yet another example common sense;
- therapy can be constructed simply as a context for learning that may also involve both unlearning and relearning and presumably would usually bear more resemblance to active learning modalities in teaching than traditional passive methods.

What all psychotherapies have in common is that they are methods of learning. All psychotherapies are intended to change people: to make them think differently (cognition), to make them feel differently (affection), and to make them act differently (behaviour). Psychotherapy is learning: one may be learning something new,

or relearning something one has forgotten, it may be learning how to learn, it may be unlearning, and paradoxically it may even be learning what one already knows (Corsini, 1980, pp. 4-5).

Therapy as release

- a therapy session can be a place for confession as people can say and do things in there that they would never dream of saying or doing anywhere else, though this goes well beyond the confession of one's supposed sins to a priest;
- catharsis is identified by many models of therapy as a positive experience for clients with some models seeing it as a priority, perhaps consistent with the Greek origins of catharsis meaning purging and purification;
- transformational experience implies a sense of change that is considerable and profound, even metamorphic, suggesting therapies with similarities to earlier practices such as those of priest healers and shamans as referred to at the beginning of this chapter.

Therapy as relationship

- transference; as discussed above;
- (re-)parenting which in some therapies involves deliberate activities to regress the client into earlier developmental states but it could also be said that there is an implied regression, or at least dependency, in many forms of therapy;
- therapy as quality company and safe human contact in which the person feels they are accepted and being heard fully in a way that does not normally occur in their world outside the therapy sessions;
- therapy as existential encounter, a concept that I see as contrasting sharply with therapy as use of techniques or therapy as analysis of transference and, similarly, therapy mediated through the application of reason;

Therapy as power

- therapy as mechanics, referring to an increasing reliance on the role of technology in assessment and treatment but also to therapists' reliance on techniques in general, all of which reflects therapies driven by reason;

- therapy as influence or persuasion, or as a means of control such as individual control by therapist over client or as social control.

These are my items, not Milton's, and reflect a potentially dark side of types of therapy and roles of therapist. The second item is particularly relevant to my discussion. Therapy has been portrayed by some critics as often being more a means of persuasion, control, constraint, even coercion than support, guidance, insight, discovery or liberation. The best known of these critiques is Against Therapy by Jeffrey Masson, in which he states from the outset his problem with psychotherapy.

> This is a book about why I believe psychotherapy, of any kind, is wrong. Although I criticize many individual therapists and therapies, my main objective is to point out that the very *idea* of psychotherapy is wrong. The structure of psychotherapy is such that no matter how kindly a person is, when that person becomes a therapist, he or she is engaged in acts that are bound to diminish the dignity, autonomy, and freedom of the person who comes for help (1993, p. 24).

PSYCHOTHERAPY AS INFLUENCE, PERSUASION OR CONTROL

> … the psychotherapies could be viewed as psychological means of '*influence*' with a trusting relationship with a designated therapist acting as an impetus for change (Wolman, 1983, p. 55, my italics).

What is meant by the terms 'influence', 'persuasion' and 'control'? At first sight persuasion might appear to be a stronger means than influence to affect another person's behaviour or beliefs. This can often not be the case however as there are varying degrees of influence and persuasion, both in how a person goes about exerting an influence or trying to persuade another and what the person is influenced or persuaded to do, ranging from minor behavioural or attitudinal modifications to profound lifestyle changes. Influence is covert, not immediately obvious, perhaps operating at subconscious levels, producing effects by means that are not evident to the person being influenced. Persuasion is more often overt involving giving reasons or offering inducements in the attempt to convince the other of the superiority of one's position. Influence is often undercover and can be more insidious than persuasion when it is difficult to

detect. Control is the domination and restraint of the other, taking away from them something of vital importance.

Therapists have significant influence on their clients, including therapists who consider themselves to be non-directive and client-centred. Influence is a characteristic of human relationships in general and inevitable from therapist to client. Psychotherapists mostly do not see themselves as agents of persuasion but rather acting in a facilitative role to assist clients find their own solutions or changed behaviours. Whatever a therapist's view of the therapist-client relationship, there is an unavoidable power imbalance between the two roles that will be implicit in some relationships, explicit in others, respectful in some and abusive in others. The power dynamic is obvious with therapists who wear the mantle of expert and director but still influential, though less clear, with therapists who try to be nondirective and client-centred, often seeing themselves as guide or facilitator. This is not to say that therapist as expert or director will inevitably misuse power whereas a nondirective therapist will not. Therapists in the role of expert can still be compassionately parental and nondirective therapists can sacrifice clients' needs on the altar of their own needs. Therapists' awareness and use of the power dynamics within each therapy-client interaction is surely critically important irrespective of whatever their predominant therapeutic influences or their personality characteristics might be.

Psychotherapists hold considerable potential to influence, persuade, and even exert control over those who seek their assistance. It was pointed out earlier that the psychotherapist, as with the traditional healer, is considered by those seeking their help to possess certain skills not held by most people that can be used to alleviate suffering. These skills are made credible through socially sanctioned sets of beliefs, such as religious, science-based or professional explanations. In other words, those seeking help will normally have faith in the ability of the healer or therapist based on shared beliefs about where that ability, those skills, come from. The 'skilled helper' and the person seeking relief from suffering often form an intense relationship in which the latter sees the former as special, different to others, in a way relevant to their search for relief from suffering, and potentially able to provide the relief they seek. This is a relationship based on ascription of special status and faith in that status, conditions that render the relief-seeker open to considerable influence. Through faith, the relief-seeker will be more open to the

influence of the helper than would normally be the case. In this sense it can be argued that clients will *inevitably* be influenced by therapists and that psychotherapy *inevitably* becomes a means of influence or, at times, persuasion.

If psychotherapy is inevitably a means of one person exerting influence over another, some useful issues to examine would be:

- Which therapies are the most influential or persuasive with clients?
- Which lend themselves more readily to possibilities of therapist control or social control?
- When influence and persuasion in therapy might be helpful, benign or harmful.
- What therapist behaviours can be interpreted as forms of influence or persuasion, and what makes these helpful or otherwise?

Reason and absurdity in therapy can both be modes of influence but reason also becomes a vehicle for persuasion. I have hypothesised that reason involves persuasion to stay within prescribed limits and that this compromises the degree of change achievable in psychotherapy based on reason. Regarding control, it is difficult to think of any times when therapist control or social control of clients would have any therapeutic value other than perhaps in extreme circumstances where serious harm to self or others might occur without that control being established. The following is a selection of activities that have come to my mind as potentially or clearly forms of persuasion, influence, or control by therapists towards clients and how these fit with reason and absurdity. Other examples can subsequently be added as this is not meant to be an exhaustive list.

Rules of operation

Most models of psychotherapy include specific procedures and techniques, some found in other models and some unique to one model only. These techniques tend to reflect assumptions underlying the model and outcomes prioritised by it. The degree to which therapists working with a particular model are expected to conform to its procedures varies considerably between models. Also, the more eclectic therapists are, the more flexible they are likely to be with their

use of techniques. I have termed the prescription of procedures and techniques as 'rules of operation' keeping in mind that, as with many rules, rigidity or flexibility in their prescription and adherence to them varies between psychotherapy models and individual psychotherapists. It can be considered that the more strictly these rules are set, the more rigidly they are adhered to, and the more fervently they are imposed upon clients, then the more they become means of persuasion and control. Imposition of procedures and techniques equates with therapist power, all the more so when therapists use them without explaining to clients what they represent, as is often the case. They can also become an obstacle to the 'realness' of the therapist-client relationship, especially when therapists become more concerned with what they are doing than who they are doing it with.

> The goal of therapy is not just to do therapy: it is to help the people you are working with. I remember having a debate with a more orthodox psychoanalyst. I was doing something called active psychoanalysis and I said that it helped people. He replied loftily, "My goal is not to help people, it is to conduct analysis in the correct way." I think that very often we are too busy conducting our therapy in the correct way rather than helping people (Greenwald, 1985, p. 243).

Rigid imposition of rules of operation in therapy, with the consequent effects of dehumanising and controlling the therapy session and therapist-client interaction, are more likely to occur under the guise of reason than they are in the company of absurdity. I am depicting reason as, by definition, an instrument of persuasion to support preconceived criteria of correctness and sanity. Procedures and techniques that sit logically within a model of psychotherapy can be useful tools in this endeavour. In contrast, absurdity is anti-methodical, inconsistent, contradictory, illogical, deviant, and often spontaneous and chaotic. Although there are many ways therapists can be absurd in their sessions, as described in Chapters 5 and 6, many of these are ways of behaving rather than techniques as such. The exceptions to this are several of the paradoxical interventions described in the Chapter 6 section, 'paradoxical and incongruity-based strategies', as they can be used as techniques aimed at bringing about intended outcomes and it may be debatable whether these can be classed as absurd or as reason masquerading as absurdity.

Choice of material for therapy

Therapists often influence the course of therapy by deciding what issues being presented by clients are to be worked with during their sessions. In conjunction with the previous category, therapists can take control of what things will be dealt with in therapy and how they will be dealt with during sessions. One aspect of a therapist's role not addressed in this thesis is assessment or diagnosis, components of the medical model of treatment, and how they influence choice of material for therapy and choice of treatment methods to deal with them. Not all therapists restrain themselves this way, but those working within conventional, reason-based, evidence-based, quasi-medical models most certainly do. Absurd therapy is more likely to be responsive to material as it arises spontaneously from clients or from the therapist-client relationship.

Therapists' interpretations and explanations

Some models of therapy are explicit in their requirement that therapists should make interpretations of things clients say and do in therapy. Most analytical and psychodynamic models are the clearest, but not the only, examples of this. The therapist interprets material presented by clients and then either formulates explanations from these to the client, or assists the client to arrive at their own explanations, of possible underlying reasons for their behaviour, emotions or interpersonal problems. Therapists formulating their own explanations will require some degree of persuasion whereas clients' own explanations are likely to be influenced, both directly and indirectly, by therapist behaviours, beliefs, comments and the like. A therapist's initial interpretation will usually have some influence on clients' processing and even the model through which the therapist operates can often do so. Interpretations and explanations are expressions of reasons. As seen in Chapter 6, absurdity plays with, parodies, mocks, and overwhelms the reasons people come up with and their attempts to come up with them.

Therapy as suggestion

The degree to which a therapy session can become a vehicle for suggestion will normally depend on a client's proneness to respond to suggestion at the time and her perception of the therapist's status, ability and power. Responding to suggestion means taking in another person's idea without subjecting it to critical thought which places it closer to influence than persuasion. It also implies that suggestion occurs without reason, as can also be implied about influence, whereas persuasion usually, perhaps always, involves some degree of weighing up reasons or assessing inducements. This points to the possibility of absurdity being a source of influence and stimulus for heightened suggestibility, but unlikelihood of it functioning as direct persuasion.

Some people are generally more responsive to suggestion than are others but suggestibility can also be enhanced in certain contexts. One of the most obvious therapeutic contexts in this regard is hypnosis in which a trance-like state is induced that usually produces a heightened degree of suggestibility. Hypnotists point out that most people are hypnotisable and probably around ten to twenty per cent of the population are highly hypnotisable and become highly suggestible when in a hypnotic trance. Hypnosis provides a context in which a therapist is essentially in control of the session and the process by which clients deal with material presented to therapy. Therapists working with hypnosis usually state that clients are always in control and able to come out of the hypnotic trance any time they want, and this is often the way clients experience it. In contrast to this claim, however, clients rarely come out of the trance until they are told to do so by the therapist, they do follow and respond to the therapist's lead while hypnotised, and they do often respond to post-hypnotic suggestions well after the trance and session have ended.

There are different ways to use hypnosis as therapy. One way to differentiate between therapeutic uses of hypnosis is between direct, linear approaches and indirect, tangential

approaches. Direct, linear hypnosis is easier for the client to follow as it follows a logical route and stays focused on the specific task for which the hypnosis is being used. This is the conventional method of applying hypnosis to therapy, is based on reason, and generally accepted within medical and science-based psychology. Indirect approaches are mostly associated with the work of Milton Erickson and are much more difficult for clients to keep track of, even deliberately involving confusion as part of the induction of trance and as a way to stymie conscious processing. Ironically, indirect hypnosis incorporates several examples of absurd approaches found in Chapters 5 and 6 and yet is more likely to be a form of therapist influence on clients than is direct hypnosis. These provide examples where absurdity appears to be a bedfellow with power and, potentially, manipulation. Masson is particularly critical of Erickson on this basis, for example in the way his approach would "force the patient into accepting the therapist's definition" of "what is real, what is true, what is good" and what the outcome of therapy should be.

> This Erickson achieved through trance induction and suggestion, often made in an offhand manner so that the person receiving the suggestion (usually posthypnotic, i.e. made during hypnosis for later action) would not even know that a suggestion has been made. It is, by Erickson's own admission, the imposition of the will of the therapist upon that of the patient to change in the direction chosen by the therapist (1992, p. 274).

Further emphasising the potential abuse of power inherent in Erickson's approach, Masson is arguing that all forms of psychotherapy ultimately lead to an abuse of power. He adds:

> The Erickson technique epitomizes, in a seemingly non-violent way, …… the therapist-as-boss. Hypnotherapists are frank about what they seek to achieve: to put somebody into a vulnerable, defenseless condition, in which the person can be told what to do (1992, p. 278).

Despite Masson's claim of what hypnotherapists would say, many therapists who use hypnosis as part of their work would disagree with his description and would counter with the claim that they work collaboratively with clients to help them arrive at their own decisions. Therapists do not normally use hypnosis as a deliberate means to impose their will onto clients, though there are undoubtedly some unprofessional and unethical people who do. At least, that is not normally the intent. The question is whether hypnosis provides a context in which this becomes

a heightened possibility and whether this becomes an increased risk with indirect approaches. I am unaware of any research that has found this to be so but intuitively it would seem likely.

Labelling

Labelling can be therapeutic or oppressive, depending on various factors including the labeller's intentions, the labeller-labelled relationship, the type of label, how the label is given (such as with profound seriousness or mirth), and whether the label is believed to be reality or metaphor. Psychiatrists often attach diagnostic labels to people as though they are true, they do so with the authority of an expert which disallows the labelled to argue with them, and they use them to determine how the labelled will thereafter be treated, medically and personally. All of this is justified on the bases of reason, science and the diagnostic manual in vogue at the time. It can be, at different times, any one of influence, persuasion individual control or social control. In contrast, absurd labels can be humorous, thought-provoking, imagination-provoking, stimulating and liberating. Several examples of absurd labelling, and discussion of their therapeutic use, can be found in Chapter 6.

Therapists believing they are supposed to be in control

Some models of psychotherapy, and some therapists, proffer the belief that therapists should gain control of the therapeutic relationship, whether as expert or in what they see as an inevitable struggle for control between therapist and client. Quite different therapy models advocate this view, such as analytical psychotherapies, some examples of behaviour therapy, and some approaches to strategic brief therapy (e.g. Haley, 1963). Opinions about the role of therapist in this regard range from therapist as 'boss', through therapist as caring expert, therapist as "professional nagger" (Farrelly, personal communication), therapist as guide and therapist as co-traveller, to therapist as "dedicated co-sufferer" (Greenwald, 1985, p. 237).

With so many different approaches to psychotherapy representing an enormous variation of methods, goals, beliefs about therapist-client relationship, focus and goals of therapy, and

attitudes towards reason and absurdity, the role of power, and degrees of influence, persuasion or control, will also vary enormously between therapies. Even so, all psychotherapies involve some degree and type of therapist power and some amount of influence. The danger is when power and influence become detrimental to clients and therapy moves into the realm of control.

Reason and Absurdity as Influence, Persuasion or Control

All the above examples point to the potential for reason to be a means of persuasion and control in psychotherapy. It would be unusual for absurdity to be a means of persuasion or control though Masson's comments about indirect hypnosis, which incorporates several absurd activities, such as metaphor, paradox, nonsense, incongruity and confusion, being used as a means of persuasion and control should be noted here. The important variable in this case could be the power dynamic arising from the hypnosis rather than power being inherent in the absurd activities.

This is not to say that absurdity never involves a power dynamic. Absurdity can be a means of influence but is unlikely to be used as persuasion. As has already been stated, influence is covert and potentially more insidious than persuasion which is an overt process of using reasons and inducements to convince the other. Also, absurdity can be used in the service of reason to persuade. Humour, for example, can be attached to an advertisement to increase its effect in selling a product or can be incorporated into a speech to increase the impact of a point. Similarly, political satire and caricature have a long history of attempting to change opinion.

PSYCHOTHERAPY AS SCIENCE, ART OR RELIGION

The origins of modern psychotherapy in 19th century science and reason have already been discussed. Psychotherapeutic orthodoxy continues to be entrenched in the science-reason paradigm but with so many different models and approaches to psychotherapy now in existence many do not particularly identify themselves with science, some are not restricted to reason as the major criterion for validity, and some explicitly deny the relevance of science, and in some

cases reason, as influential to their practice. Some models of psychotherapy are positioned more as expressions of art and others appear to reflect religious or spiritual influences. This has created tension between different models of psychotherapy as orthodox approaches that are presented as grounded in principles of science, reason and empiricism are sanctioned by professional, medical, academic and governmental institutions and finance while 'soft' psychotherapies are relegated to the fringes of 'alternative' therapy. Though perhaps a little simplistic, some polarities that might reflect this division could be therapy as:

- formulaic versus spontaneous;
- linear/systematic versus mosaic/systemic/circular/even chaotic;
- verbal/cognitive-based techniques versus nonverbal/experiential.

Further polarities can also be gleaned from Corsini's list of psychotherapeutic focus and operations criteria presented earlier in this chapter. Crucial aspects are therapists' perception and presentation of their role in relation to clients, such as boss, expert, guide, co-traveller or dedicated co-sufferer, and the degree to which the therapist-client relationship appears to be based on genuineness, authenticity, existential encounter or is artificial, stilted, or obscured by rules of operation. Related to this is the polarity of therapy as technology, including reliance on techniques, or therapy as relationship, encounter, being present.

Science-based orthodox psychotherapies are modelled on the use of prescribed, standardised, replicable methodologies intended as means to achieve certain goals. Perhaps these psychotherapies could be considered as quasi-science or pseudo-science, as acknowledgement that they are often based on a body of theoretical 'knowledge' from which has been developed a systematic goal-oriented technology. Therapists working within such modus operandi tend to arrive at decisions about what they see as clients' needs, about what they think they should do to respond to those needs, and what constitutes therapeutic success or failure, but do so usually within parameters defined by the model of therapy or theory of human functioning by which they are most influenced. Psychotherapists, clinical psychologists and psychiatrists often formulate their questions, interpret their data, arrive at their conclusions, and choose their actions according to their belief systems and theories and then assess the outcome of these

actions within the confines of those same belief systems and theories, usually in ways that confirm the beliefs and theories. Perhaps the activities of most scientists are not so different.

Even putting aside these implied doubts about the validity of scientific method, it is debatable whether psychotherapy can ever be a 'science' anyway and whether it is even desirable for it to be so. In my opinion it can never be nor should it ever be. Basic constructs of different psychotherapies differ, explanations of the same themes differ between models of therapy, and methodologies vary enormously, even between the approaches credited with some basis in science. In addition to this, science itself may not be so different, with assumptions of commonality of constructs and methodology also being ill-founded. It could be that trying to locate psychotherapy within the confines of science could well be a pointless venture if it cannot be sufficiently matched with the basic criteria of science and if those basic criteria might themselves be flawed in any case. This returns us to the question of what is psychotherapy's principal raison d'etre as discussed in the section above. Is it to be scientific, verifiable, replicable and standardised? Or is it to help people? Furthermore, if it is to help people, is it to help people be normal or is it to stimulate them to become other than they are, even if that is absurd?

Nonetheless, professional bodies insist on the need for a scientific basis to psychological and psychotherapeutic practice and are increasingly entrenching science-based criteria, procedures and measures of accountability as yardsticks of respectability, accreditation and financial support. The professional body representing psychologists in Australia, the Australian Psychological Society, in line with its USA and British equivalent organisations, firmly advocates the concept of psychology being a science and refers to psychologists as "scientist-practitioners". Professional bodies representing psychotherapists may be less captivated by the science label but are increasingly buckling under the demand to provide scientific evidence of efficacy and some standardisation of practice.

The debate will continue as to whether psychotherapy should become more science-based, or should be more influenced by concepts of art, or should dwell more in the realm of the spiritual from whence it came in its pre-science days. Orthodoxy is dictating that science, reason,

rationality, and evidence should now be the criteria by which to judge, and professionally and financially support, the different psychotherapies. Absurdity has no chance in this arena and is thereby relegated to the fringes of professional acceptability. In addition to this, the combined themes of accountability and litigation are driving absurdity further into 'the too hard basket' as they are themes based on principles of reason and its representation of commonly accepted truths, the importance of consistency, and notions of appropriateness and sanity. The reason-science paradigm may dominate psychotherapy as a profession, especially when it resides within the supra-professions of psychology and psychiatric medicine, but many heretic therapists are plying their trade in ways quite inconsistent with the science-reason paradigm. One thing for certain is that while reason and science are inevitable bedfellows, absurdity plays well with art and the more irreverent approaches to religion and spirituality. From this perspective, absurdity may allow the therapist to do psychotherapy artfully and with a sense of the spiritual, in relation, or as the existentialists would say "encounter", with clients rather than doing something to them or persuading them of something.

> In serving Art we cannot know the destination, the final product, exactly, until we arrive there. Like psychotherapy, we have to be fully immersed in the journey in order to arrive, ultimately. Paradoxically, we have to be where we are in order to get 'there'. We might have some idea where we are going. We might paint a picture and have a fantastic *journey* but not produce a work of art. But if we paint *artfully*, then we might well arrive at a work of art or something approaching one (Resnick, 1995, p. 17, italics in original).

Modern psychotherapy has mostly constituted a search for reason, whether as a search for reasons for human suffering, or a contemplation of reasons for its existence as a profession, or a search for being securely based in the foundation of reason, and by association science. Consequently, therapists too often quell any glimmer of spontaneity, sense of the absurd, mirth and words or images that appear initially to be nonsensical. They worry that such distractions from the serious activity of psychotherapy might be deemed inappropriate with clients and indefensible in a court of law. Psychotherapy is consequently often a grimly serious business. Coupled with this is the potential for psychotherapy to be a means of persuasion and control by therapists rather than a means of self-affirmation and liberation for clients. As described above,

psychotherapy comes in many forms and these vary in the degree to which they lend themselves to becoming grim or modes of control. It is my thesis that reason and absurdity provide a significant influence, probably the main influence, on how grim and how controlling the different approaches to psychotherapy will be.

CHAPTER 4: SERIOUS PSYCHOTHERAPY

Since the 1970s, two contrary processes have continued to grow in their influence on psychotherapy. On the one hand, psychotherapeutic orthodoxy in both research and practice is becoming increasingly entrenched in the science-reason paradigm, demands of accountability based on evidence-based outcome and time-limited treatment, and conformity to quantifiable, comparable, replicable methods. In contrast, there has been a rapid increase of approaches to therapy that are either unconcerned with the requirements of science and reason or, in some cases, explicitly rejecting of them. Within this proliferation, activities contrary to established norms of reason and orthodoxy-dictated practice are flourishing. These include activities considered absurd from the perspective of the established norms. University research and clinical practice in established institutions are inevitably more restricted in this regard. The role of absurdity in psychotherapy is, therefore, increasing but still minimal.

To uphold the construction of psychology as science, psychological research has mostly been restricted to the empirical study of observable human behaviour that is assumed to be governed by underlying order, consistencies or laws ultimately 'discoverable' through rigid scientific endeavour. The consequence for psychological 'treatment' is the belief that human behaviour change is best understood and attained through logical, linear cause-effect processes. As stated in the previous chapter, the main manifestation of scientific psychology as psychotherapy nowadays is CBT and its variations, together with the increasing encroachment of medical and physiological explanations and interventions on psychological treatment. This is not a receptive environment for absurdity.

While CBT has become the predominant, 'official', respectable method of psychological treatment, and observable, 'evidence-based' behavioural change the principle criterion for treatment outcome, there has also been a proliferation of other practices under the umbrella of 'psychotherapy', many of which lean on non-linear explanations of human behaviour and try to deal with non-observable aspects of human experience. Many of these new therapies reflect values of art and spirituality rather than science, thereby creating space for absurdity and, in

some cases, deliberately ignoring or even obstructing reason. There are now hundreds of psychotherapies most of which can be located somewhere in a matrix made up of dimensions of:

- science – religion – art;
- therapist as expert – therapist as 'co-traveller';
- linear cause→effect process of change – cybernetic, spiral or chaos concepts of change;
- reason – absurdity.

LITTLE DISCUSSION OF ABSURDITY IN PSYCHOTHERAPY LITERATURE

I have defined 'absurdity' as that which is contrary to reason, logic and so-called 'common sense' and, in the context of psychotherapy, it can be depicted as several activities or interventions including humour and the comical, playing the fool, paradox, irony and satire, that may lead (intentionally or not) to personal change. Discussion of therapeutic interventions based on absurdity, especially humorous and paradoxical interventions, was virtually non-existent until the 1970s and is still sparse. This type of intervention was mostly regarded as, at best, marginal and perhaps useful as quirky asides to the serious, rational, important work. Otherwise they would be seen as trivial and irrelevant or, at worst, even dangerous.

THE LACK OF HUMOUR IN PSYCHOTHERAPY

In contrast to the frequency and universality of humour and laughter as human experiences, both as personal experience and as social, shared events, they have received relatively little reference in psychological and social research literature. Part of the reason for this was that research traditionally focused on problems and dysfunction and paid scant attention to positive human behaviours and experiences. This began to change with the growing popularity of humanistic psychology and developments in youth culture in the 1960s.

Few published papers on the topic of humor and psychotherapy predate 1970. In part this reflects a longstanding taboo in the behavioural sciences which has withheld attention from other pleasure phenomena, such as love, ecstasy, and success (Kuhlman, 1984, p. 2).

Only a few years ago the editor of one social science magazine, after announcing that one whole issue would be devoted to humor research, reported receiving a number of antagonistic reactions to this announcement from his readers – even though he had alluded to articles by several eminent academics (cf. Friedman, 1969) …… Perhaps the lack of interest is at least partially a product of what Allport (1960) has termed the 'tenderness tabu' amongst psychological investigators. He complained that the majority of research workers have been preoccupied with decidedly unpleasant emotions at the expense of pleasant emotions such as love, joy and happiness (Chapman & Foot, 1976, p. 2).

As an academic discipline, psychology has focused much more on unpleasant emotions and abnormal behaviour than on pleasant emotions and everyday behaviour. For example, an analysis of introductory psychology texts published between 1877 and 1961 found that references to unpleasant emotions occurred two to three times more often than references to pleasant emotions (Carlson 1966, cited in Chapman & Foot, 1976, p. 2). The imbalance increased from the 1940s to the 1960s but began to shift back with the growth of humanistic psychology, though even with the increasing interest in optimum functioning, well-being and positive aspects of being human, psychological research into humour and laughter remained as a marginal activity.

From the mid-19th century psychology was transformed from being primarily philosophical into a discipline based on methodological observation. Early psychology laboratories, such as Wilhelm Wundt's established in 1879 which was the first of its kind, initially attempted to apply experimental observation methods to the study of mental phenomena traditionally of interest to philosophical psychology. For the early modern psychologists to stake their claim to be accepted into the new family of sciences, their focus had to shift solely to phenomena that could be studied empirically, observable behaviour, and, through systematic observation and experimentation, search for sets of principles that determine human behaviour.

Behaviourism became the defining model of psychological research and, even more radically than the other orthodoxy governing psychology at the time, psychoanalysis, was based on the reduction of human functioning into mechanical components operating predictably according to basic laws. This reductionist, mechanistic, basic law-determined, view of humanity is the antithesis to the implications of absurdity. Needless to say, humour and other forms of absurdity were mostly ignored during the first hundred years of modern psychology and totally ignored in the behaviour therapy literature until the 1970s.

Sigmund Freud and Psychoanalysis

Opinions vary about Freud's attitude towards humour and his consideration of its role in the human psyche. Within his vast amount of published writing, humour makes only few appearances, most discussion appearing as two monographs on the subject, *Jokes and their Relation to the Unconscious* (1905) [the translation I have used has the title *Wit and its Relation to the Unconscious* (1916)] and 'Humour' (1928). This stands in contrast with claims that he commonly included jokes and humorous anecdotes in his personal correspondences and that he reported the occurrence of wit and humour as being common in his psychoanalysis sessions with clients (Robert, 1968, pp. 204-205). To be fair to Freud's ability to appreciate the humorous, several writers have alluded to his use of witticisms and jokes in his therapy sessions.

> The strong resistance by professionals to viewing humor as a positive dimension of the therapeutic situation is quite surprising when we consider that the founder of psychoanalysis and psychotherapy very much appreciated wit and humor. Sigmund Freud was an active joke teller and used wit in many of his interactions with patients and nonpatients. Furthermore, he carefully subjected the many facets of jokes, humor and wit to psychoanalytic investigation. He demonstrated, for example, that humor reflects a part of the superego that looks upon the ego with the warmth and understanding of an empathetic parent. Freud showed that the superego tries to console the ego by means of humor and attempts to protect it from suffering. He also pointed out that humor has a forgiving nature and is a way we accept reality with a little more equanimity and less pain (Strean, 1994, p. xii).

Freud's statements about the psychological role and significance of humour appear to be inconsistent but this may be due to a change in his attitude towards it over the two decades between the two monographs. Consistent with the underlying assumptions of psychoanalytic

theory Freud formulated humour, in the forms of jokes and wit, as a means by which a person's ego channels their id, or instinctual energy, into socially-acceptable forms. This falls into the group of humour theories based on 'relief' or 'tension-reduction' explanations discussed in Chapter 2. His earlier work, *Jokes and Their Relation to the Unconscious* , emphasised the build up of irrational and potentially socially-threatening id/instinctual/infantile energy in a person's unconscious becoming transformed, through the defence mechanism of 'sublimation', and thereby released into the social arena in a disguised form, such as in a joke. These are socially-unacceptable aggressive, sexual, and infantile urges the super-ego cannot permit to be directly acted-out. Rather than suffering the build-up of unconscious tension caused by having always to repress them, they burst out in the form of jokes, puns, witticisms, satire and other forms of humour allowing energy to be released in laughter. His later depiction of humour in 'Humour' is more positive, emphasising its adaptive, pleasure-seeking and potentially liberating functions.

> Like jokes and the comic, humour has something liberating about it; but it also has something of grandeur and elevation …… The grandeur in it clearly lies in the triumph of narcissism, the victorious assertion of the ego's invulnerability. The ego refuses to be distressed by the provocations of reality, to let itself be compelled to suffer. It insists that it cannot be affected by the traumas of the external world; it shows, in fact, that such traumas are no more than occasions for it to gain pleasure (Freud, 1928, p. 2).

It appears that however serious Freud's approach to therapy may have been, and the fact that he does not actually discuss humour as a therapeutic tool, he did acknowledge humour as playing a useful role in the human psyche. Regardless of his later positive statements, Freud was never going to provide humour and jokes an important place in his grand theory which portrayed the human psyche as an essentially negative, limited and closed-energy mechanical system. What place could humour have in a system of therapy that was described by Freud as converting misery into normal unhappiness? Nonetheless, though poor and distant cousins to dreams in his model of the human psyche, Freud saw jokes and wit as similarly potential windows into the mosaic of the unconscious mind.

> Some may inquire whether the subject of wit is worthy of such effort. In my opinion there is no doubt about it, for even if I disregard the personal motives to be revealed during the development of this theme (the motives which drove me to gain an insight into the problem of wit), I can refer to the fact that there is an intimate connection

between all psychic occurrences; a connection which promises to furnish a psychological insight into a sphere, which, although remote, will nevertheless be of considerable value to the other spheres. One may also be reminded what a peculiar, overwhelmingly fascinating charm wit offers in our society. A new joke operates almost as an event of universal interest. It is passed on from one person to another just like the news of the latest conquest. Even prominent men who consider it worth while relating how they attained fame, what cities and countries they have seen, and with what celebrated persons they have consorted, do not disdain to dwell in their autobiographies upon this and that excellent joke which they have heard (Freud, 1916, p. 14).

Freud's model of the human psyche was mechanistic, reflecting his background as a student of biology, and he considered his approach to be scientific, but most psychoanalysts nowadays tend to view Freud as having been insufficiently scientific in both his practice and theoretical presentations. Freud's attitude towards humour may have been inconsistent, but many psychoanalysts nowadays describe humour in a positive light, viewing it as a sign of psycho-developmental maturity and some even supporting its presence in the therapy session (Strean, 1994). This is a long way from the 'no-holds' attack on its use as a therapeutic tool in 1971 by an eminent psychoanalyst at the time, Lawrence Kubie, who saw humour as destructive of the essential processes of psychoanalysis. His argument is discussed later in this chapter. The change of attitude within the psychoanalytic fraternity, as with the psychotherapy profession as a whole, no doubt reflects a shift from rigid orthodoxies to a more flexible approach to psychotherapy theory and procedures. Having said this, it would be fair to add that psychoanalytic psychotherapies continue to adhere more to orthodoxy than most contemporary psychotherapies. Moreover, they are often models of therapy producing practitioners who take themselves rather too seriously. This was certainly the case with traditional psychoanalysis, a point quite forcefully made by Pittman, an advocate of humour in therapy. His comments can be seen as starkly contrasting the descriptions of absurd therapy in the next chapter.

Psychoanalysis, despite Freud's most optimistic intentions, was soon stereotypically mired in an air of tragedy, conducted in an atmosphere of shame-based privacy and confidentiality, concerned with the inexorable thrust of overpowering emotions deep within an overriding unconscious, and carefully restricted to the unique pain of the single patient. The stereotypical psychoanalytic therapist would sit still and silent, as he or she avoided comparing experiences and contaminating the 50 minutes of self-pity with another human point of view. The psychoanalytic posture became a joke to everyone except the analyst and the patient (1995, p. 38).

Alfred Adler

A number of Freud's initially closest psychoanalyst colleagues, notably Alfred Adler, Carl Jung and Otto Rank, became uncomfortable with the negative and bio-mechanistic aspects of his model. Adler is of particular relevance to my topic as his move away from Freud led him to develop a therapeutic style in which humour and paradox featured prominently (Weeks & L'Abate, 1982, pp. 7-9).

Adler saw the primary human drive as not sexual but a striving for mastery and competence. Like Freud, he considered early childhood experiences important but in his view this was because young children feel helpless and inferior in comparison with older children and adults and so strive to overcome this sense of inferiority by developing new abilities and skills. Unlike Freud, he believed people had to be understood in their social contexts and in terms of their subjective 'realities' of self-perception and ability to work towards achieving their goals. In this light, depiction of the therapist-client relationship differed from the inherent inequality of 'psychoanalyst as expert' to one of equality based on mutual respect and collaboration (Adler, 1956). Different models of therapy reflect differences in this regard and traditional psychoanalysis and behaviour therapy both leaned heavily towards the 'therapist as expert' position.

Absurdity, especially as therapeutic humour, can flourish in relationships based on equality but tends to be stifled, or becomes abusive, in unequal power-based relationships. It is of little wonder that traditional psychoanalytic sessions and behaviour modification sessions were mostly humourless and contexts in which humour would normally be interpreted negatively, for example as "avoidance behaviour" or simply off the track. Adler's positive view of human personality, his emphasis on multiple subjective 'realities', and his model of therapist-client equality and mutual respect create an environment in which absurdity is not only given a place but is valued as a positive influence for change. Not surprisingly then, Adler, in contrast to Freud and subsequently the behaviourists, had a great deal to say about humour and paradox as therapeutic tools and he advocated the therapist's use of a variety of humorous and paradoxical

techniques. An Adlerian therapy session must have looked very different to a session of Freudian analysis or a behaviour therapy session.

Behaviourism

The rise to dominance of behaviourism in psychology reflected the goal to establish psychology as a science, specifically the 'science of human behaviour'. Behavioural psychology was restricted to studying only that which could be observed and thereby measured, that is to say phenomena that could be manipulated and controlled. It considered the non-observable, and therefore non-controllable, to be outside the domain of scientific psychological relevance. Concepts such as 'mental', 'mind', 'emotion', 'hope', 'faith' and 'humour' were considered non-quantifiable, and non-controllable, and therefore of no interest to a science-based academic psychology. How people behaved when thinking themselves to be having an emotional experience was of interest but the 'internal experience' was not. Consequently psychologists did not, on the whole, write about emotions and mental phenomena and there was no mention of humour in the behaviour therapy literature before 1970 (Kuhlman, 1984, p. 3).

Behaviourism, at least during the first fifty years between 1920 and 1970, explained and studied human behaviour, however apparently complex it could be, as being reducible to simple components operating according to a basic law or principle of stimulus – response. Behaviour was seen as predictable and able to be determined and manipulated. Behaviour therapy grew out of the empiricism-behaviourist-science paradigm dominating psychological research and reflected its assumptions and priorities. The goal of therapy was observable, measurable behaviour change brought about by standardised procedures developed through experimentation and evidence of outcome. This is the root of the concept of psychologist and therapist as 'scientist-practitioner'.

Though not providing a fruitful environment for humour, behaviourism did however generate a few techniques that could pass as paradoxical as they involved performing a problem behaviour as a means to eliminate it. Despite these examples, behaviourism and CBT are essentially based on a linear model of cause and effect allowing them to be broken down into formulaic step-by-

step procedures for ease of training university students. Even rational emotive behaviour therapy (REBT), in which humour is explicitly used to help clients see the irrationality of their thinking and consequent behaviour, is essentially a linear process based on the assumption that the rational is superior to the irrational and should therefore be the primary therapeutic goal.

Humanistic Psychology

Humanistic psychology was developed in the 1950s and 1960s by a number of academic and clinical psychologists in the USA who rejected the essentially reductionistic and deterministic models of psychoanalysis and behaviourism. It shared features with existentialist philosophies and therapies that developed within this tradition are generally referred to as humanistic-existential therapies.

The humanist criticism of psychoanalysis focused on its depiction of human behaviour and personality as determined and driven by primitive psychosexual instincts. Similarly, the humanists criticised the behaviourist claim that humans could be understood through the study of animal behaviour, in other words that animal behaviour and human behaviour were built with the same components, and that all behaviour was determined by environmental factors and governed by basic laws. The humanistic-existentialist call was to see humanness as special, irreducible to basic building blocks, characterised by free will and the ability to choose, and driven by a natural tendency towards growth and optimum functioning.

With the development of humanistic psychology, some psychologists shifted their focus onto the more positive aspects of being human, such as spontaneity, ecstasy and love, and pursuing themes of human potential and self-actualisation, which, to some degree at least, allowed humorous experience to become a legitimate component of the psychotherapy session. Nonetheless, humanistic and existentialist therapy sessions could be very earnest events, usually devoid of humour. The early humanistic psychologists appear to have taken themselves, and their mission, very seriously. According to one report, one of the founders of humanistic psychology, and its most famous therapist, Carl Rogers, had the following response to the suggestion that humour might have a role in therapy.

I said that I thought psychotherapy should be fun. When I said it, I was sitting close to Carl Rogers. I saw the red start at his collar and spread up and go over his face, and finally he burst out, "I think its hard work, and if you think its fun, then to hell with you" (Greenwald, 1975, p. 114).

Academic humanistic psychologists mostly saw themselves as still doing science though began to assert that the concept of science as applied to psychology had to expand to study non-observable aspects of human experience. They were still, essentially, trying to operate within the science-reason paradigm.

Science, as it is customarily conceived by the orthodox, is quite inadequate to these tasks. But I am certain that it need not limit itself to these orthodox ways. It need not abdicate from the problems of love, creativeness, value, beauty, imagination, ethics and joy, leaving these altogether to 'non-scientists', to poets, prophets, priests, dramatists, artists, or diplomats…….Science is the only way we have of shoving truth down the reluctant throat. Only science can overcome characterological differences in seeing and believing. Only science can progress (Maslow, 1968, p. viii).

An enthusiastic assertion by one of the founders of humanistic psychology, though perhaps a little surprising in its "shoving truth down the reluctant throat" analogy, given humanistic psychology's emphasis on things beautiful and harmonious. On the other hand such a statement makes sense if viewed from the depiction of reason as an irresistible and convincing means of persuasion as discussed in Chapter 2. The founders of humanistic psychology were academics (though Carl Rogers was also a clinician) and were committed to research and the belief that psychology was essentially a science, albeit an expanded concept of it as a science. Though it was not clear how this new science of psychology was to be conducted, the concept was still being advocated in the 1970s, as in the following statement by academic humanistic psychologist John Rowan, then the Chairperson of the British chapter of the Association for Humanistic Psychology:

Humanistic psychology …… is a whole different way of looking at psychological science. It is a way of doing science which includes love, involvement and spontaneity, instead of systematically excluding them. And the object of this science is not the prediction and control of people's behaviour, but the liberation of people from the

bonds of neurotic control, whether this comes from outside (in the structures of our society) or from inside (Rowan, 1976, p3).

Specific guidelines as to how science-based psychology could be transformed do not appear to have been developed but the concept did pave the way for more qualitative approaches to research. If anything, the humanistic research methods being proposed were alternatives to, rather than extensions of, traditional scientific research methods, and were based principally on either phenomenological or participatory-experiential approaches. Early humanistic psychology had its origins in academic psychology and appears to have been constrained by the belief that it had to remain within the, supposedly expanded, bounds of science. As the humanistic-existentialist view quickly flourished well beyond the walls of universities into therapy sessions, group activities and social movements, those calling for it to use science became less influential. Humanistic psychology entered counselling and psychotherapy, education, organisational psychology and management theory, and social action. The catch-phrases were "personal growth", "human potential" and authentic interpersonal "encounter". Boundaries between disciplines, philosophies and practices were crossed. Humanistic psychology grew out of academic psychology, management training groups, Eastern spiritual traditions, art, Existentialism, and psychedelic drugs. Personal growth and human potential activities could be a mix of therapy, encounter groups, movement and dance, meditation, music, using art and clay, techniques developed from drama, bodywork and nudity. Centres for personal growth and encounter, mostly in group activities, were established in North and South America, Europe and Asia, starting in 1961 with the most well known of them all (and still extant), Esalen Institute in Big Sur, California. Participants in activities at these centres could expect to experience a myriad of emotions but the aim was to unfold what was believed to be their natural tendency towards optimum functioning and positive experience of themselves and their lives. Humanistic psychology had shifted the focus from human limitations to human possibilities and from the conflictual and deterministic models of psychoanalysis and behaviourism to emphasise co-operation, human aspiration and 'peak experiences'.

Finally, psychology, or at least one branch of psychology, appeared to be nurturing environments in which positive emotions could be explored and, given the goals of love, joy and

honesty, might foster much mirth and laughter. In the late 1970s I was an active participant in activities organised by the Association of Humanistic Psychology in Britain and can report that, along with the usual crying, screaming and cushion-bashing, most group sessions also aroused tears of joy, laughter and a great deal of hugging. Nonetheless, even with the new focus on positives and optimistic outlook of humanistic psychology, humour as a subject of research remained fairly peripheral and in the shadow of characteristics considered more important and fundamental, such as 'human potential', 'authenticity' and 'self-actualisation'. As psychological research began to look more at positive aspects of human behaviour and experience, humour continued mostly to be ignored by researchers.

Eclecticism: Psychotherapy as Science, Religion or Art

Most psychologists, especially academic psychologists, see their discipline as a branch of science, striving to be empirical in their research and evidence-based in their clinical practices, leading to the concept of 'scientist-practitioner' endorsed by psychologists' professional bodies such as the Australian Psychological Society (APS). This role of psychologist as a practitioner working within the parameters of science is reflected by the APS Mission: "To represent, promote and advance psychology within the context of improving community well-being and scientific knowledge" (APS, 2005). The APS position that psychology is a science is unequivocally stated in one of the goals to achieve their Mission, to "improve support for the scientific discipline of psychology" (APS, 2005).

The contrivance of psychology as a science emerged in the late 19th century but suffice to say at this point that psychology did not simply appear as a new discipline but grew out of a realm of study concerned with philosophical and spiritual questions. From the 15th century, psychology (as it was already named) was the study of the human soul until the 18th century when it moved away from the religious connotations of 'the soul' to become more of a philosophical analysis of mental phenomena, in other words 'the mind'. By the early twentieth century, psychologists were enthusiastically arguing their case for acceptance into the scientific 'brotherhood'. Consequently, non-observable and thereby non-measurable concepts, such as 'soul', 'mind', 'emotion' and 'experience', had to be disallowed as useful concepts. The new science of

psychology became the science of behaviour; scientific psychology was to become a behavioural science and the orthodoxies were to be behaviourism and empiricism.

In many ways, psychology's science-religion dichotomy is paralleled in psychotherapy. Psychotherapy is essentially an offshoot of modern psychology, albeit in conjunction with medicine, particularly psychiatry. Most pre-science techniques for personal and emotional transformation were grounded in religion, spirituality, philosophy and 'magic', and often involved forms of art such as dancing, singing, chanting and painting. Unlike psychology, and perhaps partly as a reflection of these earlier practices, the debate over whether psychotherapy is science, religion/spirituality or art is thoroughly alive with many proponents of each position, as well as the idea that it can be all of them. This was not always the case, particularly during the periods dominated by theoretical orthodoxies, notably psychoanalysis and behaviourism and, to some degree, the earlier stages of humanistic psychology. Orthodoxy requires adherence to central tenets and fosters intolerance of variety, processes surely at odds with the goals usually associated with psychotherapy.

> Consider that the pioneers within each school of thought were earnestly seeking methods to alleviate human pain and suffering – and that all espoused the scientific method. As their ideas gained recognition, students and adherents gravitated to them and bestowed an aura of solemn admiration upon their work. Theoretical 'camps' developed whose early behaviour toward each other displayed a rigidity and ethnocentrism more commonly associated with religions and cults (Kuhlman, 1984, p. 4).

For close to a century, from the 1870s through to the 1960s, psychotherapy was based principally on the psychoanalytic and behaviourist orthodoxies. With the growing influence of humanistic and existentialist psychologies since the 1960s there has been an explosion of many different types, models and practices of psychotherapy and a preference for eclecticism by many, probably most, practising psychotherapists. This represents a shift from the rigidity and exclusivity of theoretical orthodoxy to the flexibility and integration of many and highly varied approaches to psychotherapy. The beginning of this shift also correlated with the dramatic youth-cultural events of the 1960s in Western societies that fostered themes of spontaneity, passion, mind-expansion, peak experiences and 'matters of the heart', all of which are consistent with themes characterising the shift in psychotherapy (and, for a while, even some academic

psychology) from orthodoxy to eclecticism and from measuring behaviour to focusing on experiences.

With eclecticism came a re-engagement in psychotherapy with existential issues, with emotional experiences, with spirituality, with creativity, with the co-existence of multiple realities, and with an exploration of alternatives to orthodoxy. Paradoxical, transpersonal, creative, nonverbal and intuitive methods and approaches to psychotherapy gained more popularity. Therapists began working with physical processes, such as movement, dance, touch and breathing to produce emotional effects. They turned to art and dance, to techniques derived from Eastern philosophies and spiritual practices, often developing into approaches aimed at bypassing or temporarily paralysing rational cognitive processing.

The emerging eclecticism revived some earlier influences on psychotherapy, such as spirituality, direct experience, creativity and art, and nonrational routes to constructing understanding the world – characteristics that can co-exist with humour. Humanistic psychology and many of the new psychotherapies also refocused research and clinical practice onto more positive aspects of being human and onto the concept of human potential. Research psychologists became interested in motivation, self-efficacy, altruism, courage, happiness, and self-actualisation while many psychotherapists began to change their language from terms such as maladaptive, dysfunctional and behaviour modification to empathy, transcendence, self-realisation and personal growth.

The development of eclecticism and increasing focus on positive aspects of being human has led to the valuing of spirituality and art in psychotherapy, rendering science as no longer the sole criterion. This has also created a more fertile ground for humour in therapy. This does not contradict Kuhlman's statement that:

> Psychotherapy has thus evolved as a hybrid of science and religion; these are two areas of human endeavor with which humor is seldom compatible (1984, p. 4).

For example, the compatibility of humour and religion varies between religions and components within religions. Whereas religious orthodoxy, as with psychotherapy orthodoxy, can be too rigid to be compatible with humour, spirituality can often produce humour. The religious and spiritual philosophies that have most influenced eclecticism in psychotherapy, such as Buddhism, Taoism and some of the mystical traditions in otherwise sombre religions, such as Sufism, abound with stories and practices characterised by humour and paradox.

Accompanying the proliferation of literally hundreds of different types of psychotherapy has been an increase in attention to the role of nonrational ways of doing therapy, such as somatic techniques, use of art and movement, visualisation, paradox. As mentioned earlier, even with humanistic psychology's refocusing on positive aspects of being human, humour received far less attention than other human potentialities such as authenticity and personal growth, despite it being a fundamental aspect of them. Despite its focus on positive attributes, humanistic psychology was mostly performed as an earnest, at times zealous, activity.

Over the last couple of decades, the science-reason paradigm has had its dominance reasserted with empiricism and genetic/neurophysiological explanations of human behaviour becoming the orthodoxy in research and cognitive-behaviourism as the orthodox (and in many clinical settings, the only permitted) form of psychological treatment. Eclecticism is still common in psychotherapeutic practice though some of the methods deemed as eccentric (which perhaps equates with nonrational), when compared with orthodox 'talking' rational therapies, appear to be increasingly viewed with suspicion as either unethical or ineffective (not evidence-based). Humour is gaining more research attention and consideration as having a therapeutic role, though discussions mostly reflect a need to make sense of, or provide a rationale for, the use and effects of humour. The demand for verifiability and accountability require the subject to be placed within the framework of reason.

Criticisms of the role of humour in psychotherapy

Wariness about the role of humour in psychotherapy can still be found amongst clinicians and psychological researchers and even some humour researchers have questioned the role it can play in human endeavours such as psychotherapy.

Most of us are aware that several prominent professionals have spoken and written negatively about the presence of any humor in clinical procedures. As I write this preface, a highly qualified and widely respected humor scholar was quoted as warning that humor has a dark side that could contaminate any enterprise in which it was involved – as if this were a unique characteristic of humor. He wondered if humor might be a narcotic to which humans are addicted, allowing humor to be useful in some situations and detrimental in others (Salameh & Fry, 2001, p. xi).

The point is valid. Even if humour and other forms of absurdity can be effective as forms of therapy they also have the potential to be damaging if used inappropriately, such as when the therapist is not empathic, perhaps even being derisive or dismissive towards the client, or when the form of absurdity might be inappropriate within a therapeutic context, such as sarcasm, telling abusive jokes, or using humour to trivialise the client's problem. Nonetheless, as alluded to in the previous quote, the potential of damage from misuse is not unique to humour or other forms of absurdity. The psychotherapeutic relationship is a powerful one in which therapists can be endowed with considerable power and clients potentially very vulnerable. Even the most compassionate therapists can inadvertently contribute to clients' suffering. Fry adds:

But, as I implied, his concerns could apply to any element of human behaviour. Even mother's love can be too much in some circumstances, and religiosity can be tainted with the sin of scrupulosity (Salameh & Fry 2001, p. xii).

Jeffrey Masson goes further in his book *Against Therapy*, describing all psychotherapy, irrespective of type of therapy or therapists' characteristics, as inevitably dangerous and destructive. It is worth repeating part of a quote given in the previous chapter.

The structure of psychotherapy is such that no matter how kindly a person is, when that person becomes a therapist, he or she is engaged in acts that are bound to diminish the dignity, autonomy, and freedom of the person who comes for help (Masson, 1993, p. 24).

This might be an extreme position but it does point to crucial aspects of the therapist-client relationship, such as power and dominance and the potential for abuse, themes relevant to this thesis. It is my contention that reason-based therapies inevitably create power and dominance, and thereby the potential for abuse, whereas absurdity-based therapies do not unless they are really reason masquerading as absurdity or are absurdity turned into viciousness, such as in sarcastic 'put-down' humour.

Of the little that has been written about humour in psychotherapy, almost all has been supportive of its use. Criticisms of its use have mostly focused on specifics, for example the risk in using humour with certain kinds of clients or psychopathologies, such as paranoid or deeply grieving clients, or by rejecting the use of particular types of humorous interventions, such as sarcasm or belittlement. Disagreement with the use of humour in psychotherapy in general has mostly been in the form of simply rejecting and then ignoring it. This traditional lack of support for the role of humour in psychotherapy is intriguing in face of the rarity of claims that humour should never be used in therapy. Just one author, Lawrence Kubie, in his article "The Destructive Potential of Humor in Psychotherapy', published in 1971 in the *American Journal of Psychiatry*, stands alone in his condemnation of humour in therapy and his attack on therapists who use humour or, as he puts it, "misuse something they misterm 'humor'" (1971, p. 866). Kubie acknowledges some of the positive aspects of humour, mainly as a "social lubricant" in "ordinary social situations" but calls it a "dangerous weapon" in the special psychotherapeutic relationship, which he calls "one of the most important relationships in the world". He states the obvious when warning that humour is not necessarily useful to a client just because the therapist is amused, a point with which therapists who use humour in their work would, I trust, agree.

> … the mere fact that it amuses and entertains the therapist and gives him a pleasant feeling is not evidence that it is a valuable experience for the patient or that it exerts on the patient an influence toward healing changes (1971, p. 861).

As stated earlier, the move from theoretical orthodoxy and rigidity in psychotherapy, characteristic of psychoanalysis and behaviourism, towards theoretical diversity and eclecticism of practice both created and reflected a greater valuing of the more positive and hopeful aspects of being human. In such a climate, outright condemnation of the role of humour will find little or no sympathy. Kubie's background, and his perspective in the article, was psychoanalytical, based therefore on theoretical orthodoxy and prescribed modes of psychotherapeutic practice, but it was written in 1971 right at the beginning of modern discussions and exploration of innovative approaches to therapeutic practice (and many other aspects of life), including the use of humour and paradox.

Many discussions of humour in psychotherapy refer back to Kubie's article, in most cases acknowledging his points but arguing against them. Kubie strongly expresses a number of reasons he believes indicate the inappropriateness of humour in the therapeutic relationship, all of which reflect assumptions underlying what had been seen to be the proper practice of psychoanalysis.

A typical example of this was his belief that the therapist introducing humour during a therapy session would impede or corrupt clients' free associations, a key psychoanalytic technique, and their flow of experience, and would thereby restrict the range and spontaneity of their responses. From this narrow view of the psychotherapeutic process and relationship the only reasonable conclusion could be that such a potent influence as humour will inevitably restrict and shape clients' responses. An alternative view is that humour and other forms of absurdity can stimulate new, and a greater range of, responses. In other words, humour can be construed as having a useful, even liberating, therapeutic impact. For example, where the client's presentation reflects an entrenched chronically habitual self-defeating cognitive pattern, the potential for a humorous intervention by the therapist to interrupt that pattern, to turn it on its head in mid-flow through shock or incongruity, could be of considerable therapeutic value in enabling the client suddenly to see another, perhaps absurd, side to their thinking. Examples of this are provided in subsequent chapters.

Another of Kubie's criticisms was that humour can become a means of avoidance and defence against the client's anxieties thereby preventing therapy from helping the client overcome them. He added that humour can also become a means of defending therapists against their own anxieties and even be used as a tool for the therapist to engage in self-aggrandisement, "parading himself as a wit" to clients and colleagues. Oddly, he believed the therapists most likely to do this were the more "constricted, sober, and humourless" of the profession. He saw this as a form of countertransference:

….. as the therapist smuggles humor in as a gesture of enticement. Humor is perhaps the most seductive form of therapist wooing (Kubie, 1971, p. 866).

Thus, for Kubie, humour becomes a "dangerous weapon" to satisfy therapists' needs to be approved of by clients thereby compromising clients' needs to act out their projections and anxieties in therapy to resolve them. Linked to this point, and also reflecting the restrictive traditional psychoanalytic view of therapists' role vis-à-vis clients, is Kubie's observation that humour "impairs the therapist's necessary incognito". It was this theoretical position that determined that psychoanalysts had to occupy a physical position behind the 'patient' outside their visual field so as not to influence their flow of associative consciousness.

It would be difficult to introduce absurdity as a therapeutic approach into the traditional psychoanalytic environment, one which, it could be argued, was itself absurd in its rigidly prescribed artificiality. In presenting his argument, Kubie emphasised the fundamental difference between the therapist-client encounter and relationship and other contexts of social interaction. He acknowledged humour's complex role in general human interaction, at times aiding communication and promoting affection but at others used to defuse and distract and even harm people. His point is that the therapist-client relationship is unique and the therapist's position very powerful. The impact of humour is therefore very different.

Humour has its place in life. Let us keep it there by acknowledging that one place where it has a very limited role, if any, is in psychotherapy (Kubie, 1971, p. 866).

Though stating that his intention was not "to persuade anyone *never* to use humor or that humor is *always* destructive." (Kubie's italics), he leaves the reader in no doubt of his position.

……over long years of experience as a therapist and supervisor, I cannot point to a single patient in whose treatment humor proved to be a safe, valuable and necessary aid (1971, pp. 864-865).

The traditional lack of support for the role of humour in psychotherapy also becomes intriguing in face of the amount and, in many cases, ferocity of responses to Kubie's article in letters published in the next issue of the *American Journal of Psychiatry*. A frequent focus in these responses was Kubie's demotion of humour from its rightful place as a fundamental aspect of human existence and wellbeing and the implications of his position that therapy be somehow protected from such an essential characteristic of emotional and social life. Some umbrage seems also to have resulted from the inference that therapists may be incapable of determining when and how their use of humour would be appropriate and potentially therapeutic, and the claim that it hardly ever, or never, can be.

I would like to add a final comment about Kubie's article that has direct relevance to one of my hypotheses. His intentions do appear to have been honourable, stemming from concern not only about clients' needs being compromised but also the risk of imbalance and abuse of power in the therapeutic relationship. He observes that therapists are automatically in positions of power in relation to clients and must therefore be careful not to employ techniques that could render that power abusive. His fear is that humour can blind therapists to their power as it clouds their ability to "remain emotionally objective and uninvolved". Although this reflects Kubie's restrictive view of the therapist's role, consistent with his training, it can be said that there is a potential risk for insensitive use of humour to become damaging and an assertion of power.

Instead of discarding absurdity as too risky, it is more useful to study its use in change contexts to try to identify the variables that influence where it can be useful and where it may be damaging. This can be said about all change-oriented approaches, interventions and techniques though it is probably more important with absurdity than it would be with more straightforward, linear approaches with explicit methodologies and goals. Judging by the

increase over the last three decades in publications on humour and paradox in psychotherapy, attitudes within the profession towards their usage are changing. Nonetheless, the idea still seems to arouse suspicion and opposition in many practitioners and comments similar to those quoted above by Kubie and Kuhlman's colleagues are not uncommon. The same reactions and sentiments are still often aroused.

LACK OF RESEARCH INTO ABSURDITY

The lack of discussion of absurdity as a change process, in the professional and clinical literature, is reflected by the lack of research attention it has been given. As discussed throughout this thesis, absurdity can be a potent means to facilitate change to human behaviour. Despite this it has rarely been seen as deserving enough to warrant much research time and funding. Perhaps "not deserving enough" can be re-read as "not serious enough" a topic for research. As discussed below, this lack of attention probably stems from the predominance of rationality and science-based values in psychology and psychiatric medicine. These are worlds in which the irrational or non-rational, the illogical and the nonsensical are usually seen as foolish, perhaps dangerous, distractions from the serious pursuit of truth; as meaningless diversions from the systematic revelation of reality. Seekers of a logical order to things, an understandable commonality underlying phenomena, will tend to view absurdity as not only a distraction from their search for 'truth' but as 'anti-truth' in that it is based upon illogical procedures and leads to illogical and invalid results that probably could not be replicated anyway.

Few examples of absurdity in psychotherapy appeared in the clinical and research literature before the 1970s though the topic has slowly gained increasing attention since then. Nonetheless, empirical research continues to be comparatively rare and the few reports that have appeared mostly attract little interest or response. There appears to have been more research into the therapeutic use of paradox than humour and it was being discussed much earlier than humour. The first clinical applications of paradox were presented by a contemporary of Freud, Alfred Adler (Weeks & L'Abate, 1982, pp. 7-9) and the first intensive research projects to study the role

of paradox in changing human behaviour were being conducted in the 1950s (Bateson et al, 1956; Watzlawick et al, 1967, 1974). The use of paradox as therapeutic strategy became widely known in the profession through the work of Victor Frankl (1967, 1975), Milton Erickson (Zeig 1980, 1985), Jay Haley (1973), and the Milan Family Therapy School (Selvini Palazzoli et al, 1978; Boscolo et al, 1987).

In contrast to paradox, the psychology of humour and its role in psychotherapy received little attention before the 1970s. Early behaviourism included some paradoxical techniques, such as 'negative practice' developed by Dunlap in the 1920s but otherwise there was not a mention of humour in the behaviour therapy literature until the 1970s (Kuhlman, 1984, p. 3). Psychologists' lack of attention to humour seems odd considering the ubiquity of humour and that it appears to be more obvious and apparently everyday than paradox. Jacob Levine (1969) presented some early studies on the psychology of humour and a range of commentaries on empirical issues published in 1972 can be found in Goldstein & McGhee (1972). The first practitioners of psychotherapy to present substantial discussions of their work with humour were Harold Greenwald (1967, 1975), Harvey Mindess (1971, 1976), Frank Farrelly (1974, 1981), Albert Ellis (1977), and Walter O'Connell (1981a, 1981b).

Things are now changing and academic study of humour in general has been growing since the 1970s. Initially humour research and academic publications mostly stemmed from university English and Performing Arts departments but over time the area has become increasingly interdisciplinary, particularly with research into anthropological, philosophical, psychological, sociological and physiological aspects of humour and laughter. Most of the research has occurred in North American universities though there has been a significant increase in the number of publications from academics and professionals in Europe over the last decade. Probably the key impetus for humour research was the formation of the International Society for Humor Studies which has been organising regular international conferences on humour studies since 1976 and has published *Humor: International Journal of Humor Research* since 1988. There is also now an internet based Humor Research Group at which academics from around the world exchange research results and discussions of theory. Nonetheless these are only recent developments and humour research is still a rarity, particularly in psychology, which stands in

contrast with the universality and frequency of the occurrence of humour in human experience. As with the avoidance or trivialisation of humour in the clinical field, the lack of research stands in contrast to the psychological importance, and sign of maturity, granted by psychologists to humour as a personality characteristic and coping mechanism.

As discussed earlier, although inconsistent and limited in his references to humour, Sigmund Freud (1928) portrayed humour as an expression of maturity, love and forgiveness used by the superego to overcome anxiety and depression. Humour is mostly portrayed by psychologists and social anthropologists as a significant indicator of psychological wellbeing and sophistication and healthy social functioning. A forty-year Harvard Grant Study led to the conclusion that humour is one of the five most mature defense mechanisms or human coping mechanisms (Vaillant, 1971). The humour response, particularly laughter, is now generally believed to have health benefits, including possibly having a role in countering physical illness, as discussed briefly at the end of Chapter 6.

Therapists working with humour consistently report that clients respond favourably and express positive feelings about their experiences of humour in the therapy sessions but that, in contrast, colleagues are more likely to express doubt and even suspicion about the role of humour in therapy. Similarly, academics who venture into the area of researching humour and other forms of absurdity often report that their proposals are devalued by colleagues and in some cases treated not only with derision but also with suspicion. Both of these are typified by Thomas Kuhlman's description of his colleagues' reactions to hearing about his research project into therapeutic humour.

A front-page column in a local newspaper publicized my work on this project while it was still in its early stages. The newspaper story prompted about 25 phone calls and letters from the public during the next two weeks. All of these reactions were positive; those that came from current and former psychotherapy clients usually included an "its about time" sort of statement.

Few of my academic and professional colleagues commented on the story at all; those who did so were polite or ambivalent. A week after the story appeared, one colleague related that some of his clients had brought up the article in their therapy sessions with him. When I asked how these discussions had gone, he smiled and said

facetiously "Its all grist for the mill". Another colleague good-naturedly dubbed me the Good Humor Man: he seemed to be implying that humor in psychotherapy tastes good but has little nutritional value. I was also approached by an advanced psychiatry resident who "confessed" to me that she and her clients often shared humor and laughter in their sessions. During supervision hours she usually played down or deleted these humorous incidents because she was apprehensive about her supervisor's response – and uncertainty whether humor belonged in psychotherapy at all (Kuhlman, 1984, pp. 1-2).

A few years ago I put together a proposal to create a Humour Research Program at the University where I work. The idea was to develop cross-discipline research projects and teaching material for students studying psychology, nursing, sociology, philosophy, literature, creative and performing arts, and postgraduate mental health studies. The relevant senior academics I approached all listened graciously before advising that humour was not a serious enough subject to warrant the time, resources and additional funding the program would require. In contrast, responses from junior academics and students were mostly positive, even enthusiastic, and evaluations of my lectures on humour to health subject students, such as nursing and psychology, regularly included comments about the importance of humour and desire for more lectures on it.

WHY PSYCHOLOGY AND PSYCHOTHERAPY ARE SUCH SERIOUS (RATIONAL) ACTIVITIES

From philosophy to science

A major factor contributing to the lack of attention given to absurdity in psychotherapy research, and the slowness of its uptake into psychotherapy practice, is that the roots of twentieth century psychotherapy were in psychology and psychiatry. These are disciplines firmly based on the assumptions of science and reason. This is not to say they are always operating true to those assumptions, just that they are supposed to be if their claim to be scientific is to be seen as valid. Psychotherapy research is mostly closely linked with the disciplines of psychology (particularly clinical psychology, counselling psychology and health psychology) and medicine (especially psychiatry and psychoneuroimmunology). In some

respects, psychotherapy had earlier roots in pre-science methods of influencing human experience and behaviour in which an individual occupying the role of healer, guide, priest, teacher or spirit-channel would perform certain activities designed to provide emotional release or support to a person or persons experiencing difficulties. Many of the practices performed by the 'healer' in pre-science days would today be seen as absurd and irrational, and the outcome (healing, recovery) considered to be placebo or otherwise unconnected to the treatment; that is to say, not connected in an obvious linear or logical way.

Psychology had to go through fundamental changes as psychologists aspired to be seen as scientists. As a science it had to be removed from its earlier more philosophical foundations that would have provided room for discussions on the absurd, on humour, and on paradox. The focus moved from philosophy, spirituality and the mysterious to science and a biomedical model. It had to become more rational and serious, empirically-based, and increasingly focused on essentially negative states, such as illness, dysfunction, or maladaptiveness. The focus of psychology on the negative and serious was fairly well absolute until the development of humanistic psychology and its shift in focus to positive attributes and peak experience. Nevertheless, science and rationality continue being the predominant models for academic psychology and mainstream psychotherapy.

Therapy as verifiable, measurable and accountable

Psychotherapy is increasingly being determined by demands of accountability, verifiability, and measurements of efficaciousness and outcome – collectively referred to as evidence-based practice. This has led to a predominance of rationality- and behaviour-oriented, and therefore measurable, approaches, notably CBT, especially in funded (and therefore accountable particularly in economic terms) clinical settings and in university clinical psychology and psychiatry training. As mentioned earlier, CBT is taught as, and is supposed to be applied with clients as, a sequentially-structured and formulaic therapy. This is 'neat and tidy' therapy with no place for spontaneity, unpredictability or foolishness.

Psychotherapy can be quite unpleasant

One obvious reason why psychotherapy can be such a serious activity is that it deals with serious issues, unpleasant problems and distress. It is not surprising that, at least initially, people respond with incredulity to the suggestion there can be a place for absurdity, especially humour, in a context where people are dealing with emotional suffering and intrapersonal or interpersonal conflicts. The challenge for people involved in therapy, clients and therapists, is to be able to see the comic and the paradoxical in face of the tragic; not as a means to trivialise or deny but as a process of transcending it.

Therapists' beliefs and attitudes

There are various therapist characteristics, such as personal beliefs, attitude and personality characteristics, that can contribute to how open and able they are to include absurdity in their sessions. For example, some therapists appear to have personal difficulty seeing the comic in face of the tragic when working with clients although this does not necessarily mean they do not have a sense of humour or appreciation of the comic in other contexts. Therapists can also have some idea of the potential of absurdity and humour in therapy, and might be prepared to use them, but are not yet acquainted with ways to do so or are held back by fear or misunderstanding of their use. This is not surprising given the lack of attention therapeutic absurdity has received in the professional literature and training. This reflects the dominant influence of reason as the basis for therapy, which also means that many therapists conform to a model or style of therapy that does not give countenance or room for absurdity anyway.

Notions of progress and wellness

Reason and absurdity imply different concepts of (un)wellness, psychological (ill-)health, (ab)normality and (in)sanity. What might be considered healthy, useful, appropriate or sane from one perspective could be quite the opposite from the other. Similarly, reason tends to value progress that is linear or, if it involves multiple aspects, that is traceable to some connecting

pattern. Absurdity requires neither linearity nor pattern and will often stimulate processes that, at least from the perspective of reason, appear to be incompatible or even mutually exclusive.

Psychotherapy as serious or absurd and as adjustment or subversion

While reason implies (and can be applied with great pains to prove) a common truth or reality - an underlying commonality to all phenomena - absurdity conjures up multiple, everchanging, unpredictable meanings and realities. Irrespective of whether psychotherapists prefer to believe in a world of underlying commonality or in one of unavoidable multiplicity, they will still be faced with the dilemmas of accountability and creativity; of being methodical or spontaneous; of the 'method' or the 'madness'. Moreover, all therapists are faced with the dilemma of what they consider to be the real goals and purpose of the therapy they are conducting and what kind of change are they valuing. Change can be adaptation or transformation; normalisation or liberation. It can be imposed (even if simply through suggestion or influence) and rationalised from outside the person or can arise spontaneously and inexplicably from within. Should therapy aim for adjustment to normality (being sensible) or subversion (by seeing the absurdity of oneself, others and society in general)? When should therapy be serious and when should it be absurd?

CHAPTER 5 - ABSURD PSYCHOTHERAPY

COMPARISONS BETWEEN SERIOUS AND ABSURD THERAPY SESSIONS AND STYLE OF THERAPY

A psychotherapy session full of absurdity, nonsense and unpredictability is likely to look and feel very different to a serious session working methodically through a client's problem point by point to reach a reasonable outcome. In reality, therapy sessions are not normally clearly divisible between absurd and serious as they can often consist of both. In the vast majority of cases, the therapist will conduct a therapy session in the serious mode attempting to address aspects of the client's problem in a systematic logical manner, though occasionally communicating through nonrational means, such as with brief expressions of self-disclosure or gentle humour. In the minority of cases, where the therapist is actively working with absurdity as a major component of the session, there will also usually be periods of seriousness and reasoning occurring during the session. There are exceptions to this. In my opinion, far too many therapy sessions are conducted entirely in the serious mode, not even providing a brief moment of relief from the task at hand. This is especially likely in approaches or schools of therapy stemming from psychoanalysis or behaviourism. At the other extreme, Frank Farrelly's provocative therapy can produce sessions unrelenting in their absurdity and Farrelly himself adopts his provocative mode from the first moment of the first session with a new client.

> I start right off the first minute of the first interview going for broke after the most available clue, whether it be the client's affect, ideational content in their first question or statement, the way they look, etc. ……We suspect that if therapists look back on their experience, they would realize as we have that the first interview, usually a time of crisis, provides opportunities to engage issues with the client which may not present themselves for awhile (Farrelly & Brandsma, 1974, p. 181).

Farrelly continues being provocative even when the client appears to have consolidated changes gained in therapy, stating that by this stage:

> ……the therapist knows that the client is able to decode him, and fully realize what the therapist is referring to with his humor and provocation. He also continues to provoke the client up to and including the last interview to help

the client assert himself and break felt dependency ties, as well as to communicate that the therapeutic relationship is both real and "unreal" in the sense that although the therapeutic relationship has many of the same qualities of a good friendship, it is unlike friendship in that the goal is work, the specific reason for being is to *change* one of the participants. The client's job is to build, in the social world outside of therapy, friendships that satisfy, are honest, and equal (1974, p. 182).

Farrelly describes the client at this stage as tending to "dismiss the therapist's caricatures of him as 'out-of-date' or his 'old self'" and provides an interesting example of this kind of therapist-client interaction with the following transcript of one of his sessions.

Client. (*Thoughtfully, slowly, as though speaking with himself.*): You know …I have been getting so much warmth and real love from people lately …I can see that now, now that I'm different …But they really haven't changed that much, they were pretty much like toward me all along …And yet, I just couldn't see it, or I would explain it away …But it was there all along, and I was blind,
Therapist. (*Pauses; quietly sarcastic.*): Same old distorted perceptions, huh?
C. (*Smiling; assuredly.*): No, no distorted perceptions this time, Frank – this time it's real, and it's been real for weeks. (*Pauses; thoughtfully.*) You'd have to travel around with me for a couple of weeks to see the intensity of the warmth that people have toward me. I guess I never really, really noticed it before. But now that I'm more open to them, I can see it.
T. (*Disgustedly.*): Aw, shit, you're getting grandiose.
C. (*Shakes head, chuckles and grins*) (1974, p. 138).

To return to the different look and feel of serious and absurd therapy sessions, the following is an attempt to identify categories in which aspects of the context and style, and the nature or content, of absurd sessions may be placed. Placing these aspects of therapy style into categories might be a little artificial but it provides a structure with which to compare therapist behaviour and therapist-client interactions in serious sessions and absurd sessions. A similar exercise is conducted in the next chapter in which I attempt to place absurd therapy techniques and interventions into categories that relate to the categories in this chapter.

STYLE OF ABSURD THERAPY

I have attempted to allocate the various approaches to absurd psychotherapy into general categories of therapist style and elements of the therapist-client relationship, from which I have come up with six categories. Chapter 6 provides a more detailed description and categorisation of techniques, interventions, strategies and therapist behaviours. The categories of therapy style to be discussed now are designed to equate quite closely with these.

The first four categories in this section relate to the context of a session, such as the therapist's style; the therapist-client relationship; and the atmosphere of the session.

- Unpredictability and novelty in the session.

- The session as an engaging, absorbing experience with a high degree of responsiveness between therapist and client.

- Playfulness and humour in the session.

- Therapist's flexibility in use of self and range of issues dealt with in the session.

The remaining two categories relate to the content of a session, particularly the types of therapist interventions and behaviours.

- Nonrationality in the session, the therapist appealing to 'uncommon sense'.

- The therapist's use of indirectness and implicitness.

UNPREDICTABILITY AND NOVELTY IN THE SESSION.

Why should therapy be boring as so often it is? Why should it not be interesting, novel, surprising and fun? I recall my early days of group therapy training at the psychiatric hospital when I had to endure, along with the inpatients, lengthy periods of silence considered by the principal therapist to be a means to facilitate patients to take responsibility for the sessions. As the trainee, it was not my place to challenge this assumption despite it being obvious to everyone except the principal therapist that, instead of instilling a sense of responsibility, these ordeals simply reinforced in the patients their perception of group therapy as a tedious and useless exercise taking up valuable time that could be spent playing table tennis or watching the television. My breakthrough came during the principal therapist's three-week vacation. As the hospital was short-staffed I was given a free rein with the group and with no supervisor watching me I could do what I wanted with them. At our first meeting the group members automatically began to settle into the usual routine of staring at the floor and saying nothing. After a couple of minutes of this I pretended to fall asleep and produced an eruption of loud rumbling snores triggering first sniggers, then laughter, and eventually comments such as "give him a nudge" and "he's bunging it on". At this point I 'awoke' and apologised for my irresponsible behaviour explaining that I been awake all night worrying about how I would run my first unsupervised group therapy session with a bunch of "mute nutcases". What followed was an animated discussion, genuine and at times spontaneous interaction between group members, moments of laughter and a wider range of nonverbal behaviour than I had ever seen from any of them. These behaviours continued over subsequent group therapy sessions, even surviving the principal therapist's return. Finally, the patients were 'taking responsibility' for the sessions because they were having more fun this way than staring at the floor in silence. Interestingly the patients generalised their more animated and interactional behaviour beyond the group sessions bringing about an appreciable change in the ward environment.

The group members' responses to my novel behaviour reflected the difference between therapy as serious and thereby detached and therapy as energetic and involving. Individuals had become lost in their own private protected worlds of "this is dreary but threatening so hide inside" and the group culture that had been established and entrenched was "be private, do not interact, things are grim", quite the opposite to the proclaimed goals of group therapy. I realised these individual behaviours and social dynamics were also reflected in the ward as a whole. As seriousness and introspection were the norm, were normal, were conventional, the only way patients could break out of this stifling state was to act insane. At least this was my theory. It seemed to me that the convention of seriousness produced miserable uncommunicative people, staff included, who had to have bursts of craziness occasionally to feel alive and take a stand against the oppressive seriousness of normality. I was unsure whether I was onto an insightful analysis or this was just one of my own bursts of craziness to survive the place. In my defence, the ward became livelier, people interacted more and were more genuine in their interactions, and (at least this is how I now remember it) staff commented that episodes of psychotic behaviour appeared to have decreased.

Absurd events and behaviours are not normal or usual as in the sense of being everyday, predictable, or to be expected. They are 'out-of-the-ordinary' and therefore often surprising. Unusual events tend to grab attention and people are taken aback, becoming disconcerted and possibly confused. Typical cognitive processing becomes interrupted and disarranged. The element of surprise and occurrence of the unexpected can put the person into a momentary (sometimes longer) suspension of thought, at least rational thought, and possibly increased receptivity or heightened suggestibility to new ideas. There are correlations between incongruity or the element of surprise and novel problem-solving and insights. Perhaps this brings about a kind of positive cognitive dissonance in which the old explanation or rationalisation suddenly does not fit but, given the suddenness of the experience, a replacement has to be found immediately.

There are at least four general potential benefits arising from unpredictability and novelty in a therapy session.

- Novelty tends to stimulate curiosity which in unusual approaches to therapy can mean the client becoming curious about the therapist, what the therapist will do next, the therapy process and what it can bring to the client, and what responses the client is going to have during the session. There will usually be a correlation between how curious clients become about the therapy and how interested they are in it, how actively they participate in it, and how motivated they are to benefit from it.

- The therapist is modelling spontaneity and creativity, both of which are widely considered to be effective approaches to problem solving.

- Surprise can bypass, interrupt or short-circuit habitual cognitive and behavioural patterns. The case vignette of 'Steven' at the end of this section is a remarkable example of how this can occur even where there is also an involuntary physical component to the client's condition.

- It seems fair to assume that therapy should be memorable but in fact a lot of therapy is very forgettable. Some years ago a psychoanalytically trained psychiatrist referred a client to me who she had been seeing fortnightly for almost two years but felt had gained little benefit from therapy. At our first session I asked the client what were the main things she felt she had gained from two years of therapy and what she remembered most about it. She had to think for a while before saying, "Well, nothing particularly stands out, but she was a good listener and let me talk about things". That was as good as I got even when pressing her to recall specific events that had occurred during the therapy. I immediately decided to ensure my therapy sessions would be memorable as I would be embarrassed if any ex-client of mine went to another therapist and could not recall what had occurred during our sessions. Unusual events tend to be more memorable than usual ones and unusual therapy is probably more memorable than the talking-listening approach. Another aspect to this is that subsequent recollection of humorous or novel

events that occurred in a therapy session often triggers the emotions that were associated with those events during the session. This phenomenon is mentioned elsewhere in this thesis, such as in the case vignettes of *Gore Galore* and *Mr. Urinal Cake*.

As noted above, it seems that novelty and the element of surprise in a therapy session, and for that matter in many other situations, can trigger dramatic shifts in experience and behaviour. We normally enter situations with sets of assumptions and expectations about what is most likely to occur. When the actual events are inconsistent with our expectational sets we will usually experience a degree of confusion, disbelief or surprise. We are put off balance. When the actual events are dramatically inconsistent, incongruous or clashing with our expectational sets we can react in ways also dramatically different to our behaviour preceding the surprising event, including where this may have been habitual or even entrenched. After some time we might, and probably will, try to make sense of what happened, but our immediate reaction will usually be emotional and spontaneous, not thought about or typical, potentially making this 'off-balance' moment an opportunity to stumble upon new ways of responding to experiences.

Incongruity and surprise can jolt people out of symptomatic behaviours that appear to have been occurring involuntarily and not arising from conscious decisions or exercise of will. Late one afternoon I was contacted by the acute psychiatric ward of a general hospital for which I provided an outpatient psychology and psychotherapy service. They referred a seventeen-year old male inpatient, with no known previous psychiatric history, whose head had become twisted around as far as physically possible without damage for four days and for no known reason. A range of medical assessments had uncovered no physical cause for this, leading to the conclusion that his condition had a psychological cause and a diagnosis of 'conversion disorder' or 'hysterical neurosis, conversion type' as was recorded in his file at the time. The ward staff made an appointment for me to see this patient in one of their interview rooms in the ward at 8.30am the next day.

The next morning I was browsing through this client's file (pseudonym 'Steven') while waiting for a nurse to bring him to the interview room. I was complaining to myself that I had agreed to

such an early appointment as, being a slow starter in the morning, I rarely saw clients before 10am because "my brain doesn't wake up until then" (as I used to tell myself). There was a knock on the door and in walks a student nurse guiding Steven who is peering over his left shoulder, head twisted as far as possible to an extent that would be impossible to maintain voluntarily for longer than a couple of minutes at best. I observed that his eyeballs were similarly extended in the same direction as far as would be humanly possible. He had been in this posture for four days – indicating that this was not a voluntary, deliberate or conscious act. It would be extremely difficult, perhaps impossible, for a person to sustain such a posture for four minutes, let alone four days, as the pain becomes unbearable. This particular nurse had a slightly wicked sense of humour and, with a brief raising of her eyebrows and cheeky grin, she gently settled Steven down onto the chair to my left, rather than the obvious one to my right that would have provided me with a view of his face, leaving him twisted away from me and me staring at the back of his head.

Given the early hour and diminished brain activity I associated with this, I had no idea what to do with this young man. I knew what not to do. I knew not to do what had already been done since his admission to the ward. He would already have been put through at least three admission/assessment/diagnostic interviews with a psychiatric nurse, psychiatric registrar and possibly consultant psychiatrist – all of whom would have been talking to him, and asking him questions in a very (at least, apparently) rational manner, almost as though there was not really anything unusual going on here. It is an interesting, and often amusing, experience to witness a highly paid professional attempt to maintain a rational line of questioning and interacting with a person manifesting overtly irrational, perhaps bizarre, behaviours, as demonstrated in the psychiatric ward round scenarios described in the section on therapist's flexibility later in this chapter.

I could not see the point of putting Steven through the same routine, especially as that seemed quite ridiculous given his demeanour, but I had no idea what else to do with him so I did the best thing available – nothing. I sat there looking at the back of this strange young man's twisted head, not wanting to do the obvious but not knowing what else to do that might make sense. Ten minutes passed and I had still said nothing (my group therapy supervisor referred to above

would have been proud of me as long as she did not see that my inactivity stemmed from stupor rather than some misguided strategy) but I noticed there had been some minimal movement of Steven's head with him becoming less rigid and very slightly more oriented towards me. His head had shifted very slightly to the right, in my direction, though still not enough to have me in his visual field. "Aha, progress" I thought, but still had no idea how I might engage him directly. Another ten minutes or so passed with me being silent and him almost imperceptively letting his head move in his attempt to find out what was going on. He had been told there would be a psychologist in the room and probably assumed he would be put through roughly the same process he had already experienced at least three times. I imagine he was wondering, "Why is this psychologist silent?" and eventually, "Is there actually someone there?"

It is important to keep in mind that Steven's symptoms were severe. It is not possible for a person to sustain voluntarily the extent of neck twist he had had for four days. It is extremely difficult, and painful, to attempt to do this voluntarily for even a couple of minutes. He was not now, after four days, simply choosing to relax his neck, but he was curious about what was going on – or not going on where something should have been going on – in this interview room. His head twist was involuntary but his curiosity and the incongruity of the situation, the mismatch of his expectations and assumptions with what was actually happening, were getting the better of him.

I had managed to maintain the silence for close to half an hour (which might seem impressive but my group therapy supervisor could quadruple that) before Steven's head and eye positions had eventually moved to a point where I was fairly sure he had found me on the periphery of his visual field. I thought this was a critical phase though still had no logical idea what to do or how to engage him. The fact is that what I next did was spontaneous, made no sense, went against all my training (such as do NOT touch your client), and was potentially hazardous. I did inflict a minor physical injury on myself though fortunately Steven was unmarked, physically at least. My behaviour was absurd.

I often relate this story in training workshops and it is appropriate here to write what I usually say at this point in describing this session as, although my behaviour at the time was

spontaneous, in retrospect sense can be made of it. The following paragraph, then, is not really what went through my mind at the time, but can perhaps be a reference point, at least for people working in therapy. In the training workshops I get to this stage in the story of Steven's session and point out that at times of uncertainty it can be useful to go back to the basics. As a therapist this may mean going back to the basic principles of counselling practice.

Counselling rule number one is to establish rapport. After more than half an hour we have finally established a basic level of eye contact (peripheral in his case but an improvement on none). That will have to be good enough – as good an attempt at rapport building as can be expected under the circumstances, I decided. Rule number two is empathy. The concept of empathy is commonly portrayed in counselling courses and supervision sessions as getting inside the client's head and looking at the world through their eyes, that is to say getting as close a sense of their experience of their world as you are able. This is meant to be achieved through careful and attentive listening to what the person is saying, observation of their nonverbal behaviour, and being nonjudgemental. In a way this involves a temporary suspension of reason. So, true to the counsellors' rule book, rule number two, I climbed into Steven's head and looked at the world through his eyes.

I twisted my head as far as I could and began a nonstop monologue on how the world looked from this position, how painful it had become after only one minute and how impressed I was that he had kept it up for four days, how straining my eyes so far back as he was doing was beginning to give me a headache, and so on. At one point I commented that it was all very well for him to be like this because he had attractive young nurses holding him and guiding him and feeding him but, as I was a staff member, they would never do that for me and so if I were to try to walk about like this I would be unable to see where I was going. Then came the leap of faith as, to demonstrate what I was saying, I got up from the security of my chair and stepped forth into the unknown and unseen. Being in an interview room I was unfamiliar with, I had forgotten about the coffee table immediately in front of me over which I tumbled head over heels, inflicting the minor physical injury mentioned earlier. Not to let the pursuit of therapeutic absurdity be curtailed by a minor accident, I found my way upright and continued to stumble and crash around the room, head and eyes twisted back, running my nonstop monologue about

the difficulties of being "twisted in the head". Transgressing the unwritten prohibition against touching clients in counselling, I even managed to fall over Steven on three occasions, on the last pulling him out of his chair and both of us landing in a tangled heap on the floor. After muttering an apology and pleading with him not to report me to the ward head nurse because she would smack me, I helped him back to his chair, keeping my head twisted and talking throughout. The whole bizarre spectacle must have gone on for ten minutes until, finally, as I am listing a series of supposed, sometimes idiotic, advantages of having a twisted head I suddenly looked straight at Steven and yelled "And it's a fucking good way to avoid eye contact!". He was looking straight back at me, his arms wrapped around his ribs, tears pouring down his cheeks, convulsed with laughter. I said "You think it's funny. I think it's weird. Who the fuck are you going to such lengths to avoid facing?".

Once we had both settled down we had a fruitful discussion in which he revealed that he wanted to go to a university in another city but was living at home with his dependent and socially isolated mother. She was aware of this but was giving him mutually contradictory messages, verbalising her support for him going away to study while nonverbally pleading with him not to. She would say "Don't worry about me, I'll survive", while sighing and looking forlorn, or "You have to have your own life", followed by "but you will phone me every day". Steven could see that his mother genuinely wanted him to do well but that she also feared the loneliness associated with him leaving home. His mother was unintentionally presenting him with two mutually incompatible demands, each of which could only be met at the expense of the other: become independent, study and do well versus stay with me because I cannot survive without you. This is a paradox irresolvable through a simple linear solution.

This paradox was called a "double-bind" by Gregory Bateson and his colleagues, known as the 'Palo Alto group' from the name of the city in California at which they were conducting their research into paradoxical communication and its relation to psychopathology. Their research led to a classic psychology article 'Toward a Theory of Schizophrenia' in which they claimed that when people become subject to double-binds, on an ongoing basis, especially if from someone more powerful than themselves, they become at risk of developing symptoms of psychopathology such as schizophrenia. They considered the essential ingredients of this

pathogenic double-bind to be that a more powerful person (such as a parent) persistently presents two mutually incompatible injunctions to the less powerful person (such as the son or daughter) in such a way that to fail to obey either would result in negative consequences (such as punishment, disapproval, shame, guilt). They described the interpersonal arena in which psychopathology may emerge as being where people being subjected to a double-bind, due to lacking power, are unable either to remove themselves from the interaction or to confront it directly. Consequently their only way out becomes indirect through developing psychopathological symptoms (Bateson et al, 1956).

At the time, this struck me as a useful model to explain Steven's predicament, and I saw him as having become incapable, literally, of looking his mother in her eyes. As stated earlier, he was not twisting his head voluntarily, deliberately or from a conscious decision. That initial session, at least the pantomime component, had short-circuited whatever non-conscious processes had been driving him to do it. Subsequently, that session and the few that followed were able to discuss his predicament rationally and help him and his mother develop more honest communications and strategies to permit his leaving home and her developing other sources of support. In ten minutes at most, the therapist's absurdity in a sense liberated Steven from the psychopathological response that had held him for four days permitting him to face the problem and seek rational solutions. The fact that therapy subsequently became based mainly on reason takes nothing away from the role and status of the earlier absurdity which stands in its own right as an incongruous and surprising (also surprising to the therapist at the time) behaviour that had not been designed to lead to a specific goal but had sprung spontaneously out of an absurd situation: a young man with a twisted head for no apparent reason sitting in a very formal office with a supposed expert who had not the faintest idea what to do.

Though this is a lengthy example, it is useful because it is a vivid demonstration of how novelty, surprise, incongruity and the ridiculous can trigger immediate changes to behaviours even when they are not voluntary or even consciously understood or driven. The absurdity created the possibility for reason in a way and time frame that would have been highly unlikely to achieve with reason. Normally, in psychiatric settings, when it is seen that verbal reason is not 'getting through' to clients, reason will dictate the use of medication and other physical forms of

treatment such as E.C.T. Unfortunately, in Steven's case, the potency of the therapeutic absurdity would probably not have been appreciated by the ward staff or psychiatrists. This may seem a rash statement but it is based on previous experiences and relates to the trivialisation or suspicion traditionally leveled at absurdity's role in clinical settings. With this in mind, and from a desire to end the initial session with absurdity, I decided to present Steven with a paradoxical request of my own, especially as he had already proved to be so responsive to such communications. My request was based on the paradoxical technique 'prescribing the symptom', which is possibly the most commonly used technique in the history of paradoxical psychotherapy. It is described later in the next chapter on absurd therapy interventions, in the section paradoxical/strategic/incongruity-based interventions. While reading the next paragraph it could be interesting to speculate what my real reasons were for prescribing the symptom before reading my explanation of them.

The rationale I gave to Steven was obviously false, though he appeared to believe it. I asked Steven if he had got much from this session and was prepared to meet for a few more, to which he replied that he had gained a lot and was keen to resolve his dilemma through counselling. I asked if he felt I knew what I was doing, even if it seemed strange at times, to which he replied laughing that he did. I then asked him if he was prepared to do something for me that would be quite difficult for him but that would help me enormously and dramatically improve the benefits he would get from counselling. Clearly intrigued, he agreed. I told him that the ward did not usually send me difficult cases like him and I would like to keep it that way. I said that if they found out that his twisted head had been 'cured' in one session, they would start sending me more "really weird loonies like you" rather than the easy ones who took less effort and did not require me to fall over coffee tables and grapple on the floor with them. I asked him to revert to the head twist and keep it up for the rest of the day but to wake up in the morning 'cured' as at least that way the staff would not automatically assume I had had anything to do with it. I acknowledged that it would be difficult for him to do, that it would probably be painful, and that he probably would not be able to keep it as fully twisted as it had been previously. Nevertheless, he was a helpful, co-operative lad who liked me and was keen to impress. His motivation was probably also enhanced by my pointing out to him that this was his last chance to have that attractive young student nurse hold him so closely. The next day, I was advised by

the ward that Steven appeared to have lost his conversion hysteria symptoms overnight and was requesting both to be discharged and to have some counselling with me. I complimented them on their care for Steven and pointed out how his remarkable recovery demonstrated the value of 'milieu therapy'. I met with Steven, booked him in for some out-patient sessions and organized his discharge. As he was leaving I told him I was going to write a heading on his file: *The Case of the Son Who Was Twisted in the Head* at which he spluttered with laughter, much to his mother's and the discharge officer's bafflement.

Prescribing the symptom is a paradoxical technique and therefore at one level can be considered absurd as clients expect the therapist to help them get rid of their problem, not deliberately continue with it or, as with exaggerating the symptom, do it even more often or more intensely. Having said that, therapeutic absurdity can be seen to reflect different levels or types of absurdity or, probably more appropriately, only some examples are truly absurd whereas others only appear to be. In the initial session with Steven, twisting my head and stumbling around the room was unplanned, spontaneous, and, initially at least, was not intended to produce a specific response in the client. Prescribing the symptom at the end of the session, however, reflected at least two therapeutic aims. The first has already been alluded to. My concern was that, if Steven walked out of that interview room after only a one-hour session, his condition might be trivialised by people, most importantly the ward staff. Irrespective of the severity of it and that it had lasted for four days, the fact that it had been 'cured' in only one hour of therapy could easily be construed as meaning that it was not really a serious problem after all. This would not be because the staff were ill-meaning, rather, perhaps paradoxically, it reflects the seriousness with which clinical staff take their work and what they have to deal with in patients. Does a one-hour psychological 'cure' make a mockery of all the work previously put into this client? How can a psychologist acting like a drunken fool be better than serious analysis, medication or ward rounds unless the client was not really ill in the first place?

The second reason for asking Steven to reactivate his presenting problematic behaviour, after it had ceased occurring, arises from an assumption underlying paradoxical psychotherapy that deliberately performing normally involuntary behavioural or cognitive symptoms will diminish their involuntary occurrence. Steven was given permission to take voluntary control of what

had been a disturbing and mysterious symptom and he was able to have some fun in doing so, for example in duping the entire ward staff for a day. In contrast, it would have been difficult and painful for him to sustain his twisted head all day, for which reason I did advise him that he did not have to keep his head as severely twisted as it had been. I covered him on this by advising staff that some observable improvement had resulted from him being able to talk about things but continued improvement would be gradual and only occur in the supportive gentle environment they would be able to offer.

THE SESSION AS AN ENGAGING, ABSORBING EXPERIENCE WITH A HIGH DEGREE OF RESPONSIVENESS BETWEEN THERAPIST AND CLIENT.

An engaging, animated, highly interactional (including a lot of nonverbal interaction), encounter between people has a very different 'feel' to it than an exchange that is serious and mostly 'cerebral'. This is not, of course, just a difference found in therapeutic encounters, but throughout human interaction. The degree to which any human interaction becomes engaging or disengaging, spontaneous or premeditated, serious or comical, will reflect a number of components of that interaction, notably the relationship between participants including their beliefs, attitudes and feelings towards one another; the context in which the interaction is occurring; and personality characteristics of each participant.

Humour, and being playful and kidding about, are more likely to occur in friendly relationships involving positive beliefs, attitudes and feelings. Communication is more likely to be inclusive, accepting and spontaneous in friendly relationships than formal, power-based or antagonistic encounters. Friendly relationships are more likely to foster and tolerate incongruities and paradoxes, paving the way for word-playing, bantering and participants pretending the opposite to what they really meant. Word-play and pretence do enter relationships based on seriousness, power or opposition but they have a very different feel and intent to their occurrence in friendly relationships.

Absurdity arises easily in some interpersonal contexts but is not a natural occurrence in others. Informal social get-togethers will usually include nonsense, humour and jesting whereas this is usually not so in formal contexts, such as business meetings or ceremonial events, though this can be modified to some degree by the reason for the gathering and sociocultural factors. For example, funerals are essentially social gatherings for a specific purpose and can range from highly solemn affairs to contexts for celebrating the deceased with drinking, singing, and telling funny stories about their life. I attended a Tibetan Buddhist funeral in northern India that consisted of a highly ritualistic four days of monks chanting interspersed with children running and playing, monks often grinning and smiling, and bereaved alternating between sadness, chatting, eating, drinking, coming and going, and sometimes joking and laughing. For some, the idea of allowing mirth into solemn occasions or serious formal meetings is unpalatable whereas in some contexts, such as Tibetan funerals and Irish wakes, it is the norm.

The introduction of absurdity into serious social contexts can facilitate changes to the context, as shown in my group therapy example at the beginning of the 'novelty' section of this chapter. An interesting concept is introducing humour into formal business meetings and workplaces, some examples of which are given elsewhere in this thesis and many can be found in the book *Managing To Have Fun* by Matt Weinstein (1996). Weinstein founded a management consultancy he named *Playfair* which, in the Introduction to his book, he describes as teaching "fun-centered management skills" and the use of "laughter, fun, and play to help organizations build successful teams" (p. 11). I have run a number of workplace humour workshops and I find that most people need little persuasion or coaxing to see the value of some fun and nonsense at work. Even initial contacts can produce immediate humour responses. For example, Weinstein's official title at *Playfair* is 'Emperor' and a colleague's is 'Senior Vice Empress'.

> When I send out a business letter on my Emperor of Playfair stationery, I often receive a reply signed by the "Queen of Personnel," or "Your Obedient Serf," or "Special Assistant to the Lord of Finance." Whenever that happens, I know that we are going to enjoy a long and fruitful working relationship (Weinstein, 1996, p. 12).

Most people would consider personality to play a role in absurdity, for example that some people initiate and respond to humour and other forms of absurdity more readily and more

often than do others. This personality characteristic is often called "sense of humour" but the concept is not a simple one and may refer to different characteristics such as ability to tell jokes well, appreciation of jokes, a tendency to see the funny side of things, quick wittedness, and numerous others. People do differ in how they deal with absurdity but variations will also occur in the same individual depending on emotional, physical, social and environmental influences. Personality factors involved in absurdity are not static. For example, putting it simply, a person can be helped to improve their "sense of humour" in various ways. One of the points of having absurdity as part of psychotherapy is to help people move beyond their suffering by becoming more aware of their absurdity and the comic juxtaposition with the tragic.

There are, of course, other ways for people to deal constructively with suffering and problems. It would be fallacious to portray the comical or absurd mode as always preferable to the serious mode in human interactions, irrespective of context, though a compelling argument can be made that it is preferable on many occasions, and preferable as not only being more enjoyable but also as being more useful. The serious mode of thinking and behaving can be stifling, restrictive, and disillusioning if given free rein, never relieved or put into relief by absurdity, nonsense, or humour. This point is developed elsewhere in this thesis and supported by several authors (Mindess, 1971; Mulkay, 1988; Berger, 1997). There are times in psychotherapy when careful consideration and analysis of an issue can be productive and illuminating for clients whereas there are times when this can inhibit or confuse clients' awareness or simply impose a new rationale that might be just as misguided as the one it has replaced. There are also times when the serious mode is appropriate, sometimes essential, while still being allowed to lead into the comical at some stage and there are times when it may be inappropriate to be comical or otherwise absurd and the serious mode allowed to continue.

Frank Farrelly conducts training workshops in his 'provocative therapy' in numerous countries in Europe, the Americas and Australasia. A major component of these workshops is Farrelly having provocative therapy sessions with individuals in front of the workshop participants to demonstrate how he works. At one of his workshops in Sydney he was interviewing a man who had lost one of two sons in tragic circumstances and had since become hypervigilant about his surviving son. The man was grief-stricken, his pain intensifying during the session as he

revisited the tragedy. Farrelly simply sat with him, gently resting his hand on the man's hand, very occasionally making a supportive comment. There was no humour, no laughter, just talking and crying. After the session a member of the audience commented "But you weren't doing provocative therapy were you?" to which Farrelly responded "Shame, Shame, Shame".

Therapy sessions consisting of absurdity, especially humour, do tend to become very animated and engaging. Humour is usually entertaining and paradox is often intriguing. The more engaging, intriguing and absorbing therapy sessions are, the more interested and involved clients are likely to be. Likewise, the more interested and involved clients are in therapy, the more memorable it will usually become for them. For example, two ways absurd therapists can make a session, or a theme during a session, memorable is to give them provocative titles and associate them with bizarre imagery. Putting both of these together anchors themes in clients' memories even more. Examples of these are *The Weird Left Tit Interview* described in the "Nonrationality' section below, and *Gore Galore* and *Mr. Urinal Cake*, both described in the next chapter.

It is difficult to see how forgettable therapy, therapy that makes insufficient impact on the client for him to remember much of it, can be effective. In referring to the psychoanalytically trained therapist early in this chapter, I made the claim that therapy will normally benefit from being memorable. I would add that unusual events tend to be more memorable than usual ones and unusual therapy is probably more memorable than the talking-listening approach. Related to this is that meaningful and important experiences are more likely to be memorable than meaningless or trivial ones. The challenge for therapists is to create meaningful and important experiences that are relevant and beneficial, as well as memorable, for clients.

Similarly, many therapists and researchers have pointed out that clients' motivation to participate actively in therapy and gain benefit from it is usually a necessary component for therapy to be a rewarding experience and to be effective. A factor that can be a significant activator of motivation and possibly an indicator of therapeutic outcome, but that has received much less attention than has motivation in this context, is clients' curiosity, such as curiosity about what will happen in therapy and what can be gained from it. As pointed out earlier in this

chapter, novelty tends to stimulate clients' curiosity about the therapist, the therapy process and how they are going to respond and there will usually be a correlation between how curious clients become about the therapy and how interested they are in it, how actively they participate in it, and how motivated they are to benefit from it. Correlations between playfulness and humour with curiosity and interest have also been explored (Weisfeld, 1993) and the role of playfulness in therapy is discussed in both the following section and next chapter.

Therapists who bring novelty and playfulness into their sessions need to be highly responsive (verbally and nonverbally) to the client's cues, verbal and nonverbal, so as not to become themselves so absorbed in their play that the client loses sense of it being relevant to her rather than the therapist simply becoming self-indulgent. In my experience, therapists who bring play into their work do tend to have heightened responsiveness and often stimulate clients to become increasingly so with the therapist. This is particularly evident in provocative therapy sessions in which both therapist and client become intensely focused on one another and oblivious to stimuli peripheral to the interpersonal encounter. In his training workshops, Frank Farrelly conducts half hour sessions with individual participants, working on real and often highly traumatic problems, in front of the other participants, usually a group of anything from a dozen to a hundred people. Farrelly forbids any vocal involvement, other than laughter, from observers during these sessions. Almost every time, the 'client' reports having quickly lost awareness of the group because of the intensely engaging nature of the therapist's behaviour, even when, as is more often than not the case, the audience are in fits of laughter. After having observed several of Farrelly's therapy sessions, Bandler and Grinder, the creators of neurolinguistic programming, concluded that clients became so absorbed they exhibited behavioural signs of entering a hypnotic or hypnotic-like state (Farrelly, personal communication). Perhaps suggesting absurd therapy is often engaging is an understatement, rather the claim might be that it is entrancing or enchanting!

Psychotherapy research does indicate that the therapist-client relationship is a critical factor influencing outcome, with some of the more recent research describing it as the most critical factor (Hubble et al, 1999). I am personally aware of hundreds of verbal reports suggesting a link between client satisfaction and how interesting and engaging, or how uninteresting or

uneventful, their therapy was. Though not outcome studies, these observations are nonetheless relevant. An ex-client of mine wrote to me some months after therapy had ended advising me that she had recommended me to several of her acquaintances after learning from them that they had found therapy to be uneventful or, in some cases, boring. Her comment was, "Boy, are they in for a shock when they see you".

Finally, a comment on time-orientation in therapy. Some approaches to psychotherapy emphasise analysis of past experiences and others tend to be more focussed on current experiences even where these arise from past events. Absurd approaches to therapy tend to focus more on the present, the 'here and now', rather than embark on the psychological-archaeological digs characteristic of more analytical approaches. Farrelly explains why his therapy emphasises the present.

> Because the reality is that the present is all we've got to deal with. Clients are not trying to resolve past conflictual situations such as Oedipal complexes. They are hung up *now* in their feelings, for example, about authority and their feelings towards the opposite sex. And I would agree strongly with (Albert) Ellis that it is the *current* self-talk that clients engage in that helps to maintain their problems.
>
> The provocative therapist will use the client's past to point out how they developed their screwball attitudes and behaviors, or to simply demonstrate for how long a time a client has been self-defeating. And he will also frequently use the future to run different scenarios past the client, wild, implausible themes based on the client's present attitudes and behaviors, to provoke the "Ugh!" reaction in the client, to sensitize him to the probable consequence of his presently held idiotic ideas and zany behaviors (Farrelly & Brandsma, 1974, pp. 189-190).

Humour, especially, tends to focus the mind on the 'here and now'. Even when relating stories about past occurrences, humour tends to bring events and experiences alive allowing listeners, and often also the teller, to have a sense of directly experiencing them during the telling. Humour can arouse strong affective responses and vicarious associations, especially with stories about someone encountering a difficult and embarrassing situation. According to superiority theories of humour it is the listeners' relief from it not being them having the experience that allows them to laugh at the person who is suffering the experience. This is demonstrated in the following true story.

A few decades ago, a friend of a friend of mine (pseudonym 'Pete') had been shopping in Sydney and was running along Pitt Street to the railway station as he was hoping to catch the next train to his home-town which was a couple of hours train-journey away. He was running fast as it was only a few minutes before departure when, without warning he had a severe attack of diarrhoea. Fortunately this occurred outside a clothes shop and in desperation he ran in and asked for Wranglers, size whatever, said he did not need to try them on, begged the assistant just to stuff them in a carrier bag, threw the money at her, and sped on his way to the station. This was before the introduction of electric air-conditioned trains and he managed to leap onto the train as it was actually moving. He immediately went into the toilet and took off his trousers and underpants which were so full of diarrhoea he decided he could not face keeping them and so opened the toilet window and threw them out of the train. He then cleaned himself as best he could, reached into the carrier bag and pulled out a Wrangler jacket.

Without having been in that predicament, it is still possible to experience vividly Pete's shock, panic and embarrassment, feel sympathy with him but relief that it was him not us, and range between cringing and outbursts of laughter. Theorists inclined towards superiority explanations of humour would like this story.

PLAYFULNESS AND HUMOUR IN THE SESSION.

Definitions of absurdity always include references to foolishness and playing the fool, the comical, the laughable, and being silly and ridiculous. Given the tragedy and suffering brought into psychotherapy sessions, the suggestion that there may be a role, perhaps central, for absurdity, humour, parody and play could appear inappropriate or even insensitive, with the potential to trivialise the tragedy and pain of clients. Certainly, absurdity can be used as a means to minimise a person's problem and humour can be used as a means to devalue or insult a person or group. Obviously these are not therapeutic uses of absurdity and humour. For absurdity to be potentially therapeutic it should not minimise the tragedy but highlight it in a novel way that has the potential for triggering novel ways to deal with it. The idea of becoming

playful with, having fun with, and laughing at, a serious problem is intriguing and reflects the principle of facing difficulties rather than running away from them or pretending they are not there. This relates to the concept of therapy, and some other approaches to change, as liberation from suffering, a theme addressed in this thesis particularly in regards to the roles of reason and absurdity in therapy.

Therapy as liberation has been depicted in various ways, though only recently as involving absurdity, but it is not the majority view of therapy. Most therapeutic applications of psychology and psychiatry aim for adjustment rather than liberation, though would acknowledge liberation from suffering, in the sense of reducing it, as a desirable outcome. The concept of liberation is profound and a key question posed in this thesis is whether reason can ever be a vehicle for liberation or only a barrier to it. One assumption behind absurdity as a vehicle for liberation is that people must free themselves from the constraints of seriousness, such as by having fun, playing, laughing at the world, and enjoying the contradictions and paradoxes in their lives rather than worrying about them.

Do adults lose the ability to play or just change the way they play? There does appear to be less spontaneity, illogicality and creative imagination in adult play than in child's play – a point obviously relevant to this discussion of the characteristics of absurd therapy. Convention dictates that adults should not be childish, whatever that means. Might the assumption be: reason is adult and sensible whereas absurdity is childish and foolish, implying that there is something wrong with adults being childish and foolish. Adults even chastise or restrain children from being childish or foolish (according to the adults' definitions) with orders such as "don't be so childish" and "act your age" (which is often what the child was actually doing). It is not that adults are not supposed to be playful or have fun at all, but that they can be playful and have fun in prescribed adult-appropriate ways and only in certain contexts, such as with friends, but not in others, such as at work or in church.

Terms used to describe something often reflect the value placed on it. What are the different implications of being "child-like" as distinct from "childish" and "playing the fool" as distinct from "being foolish"? It seems to me that absurdity as a means to liberation for adults is not to

become or behave as children but to inspire child-like qualities in themselves through humour, fun, playfulness, spontaneity, and even 'breaking the rules'. This chapter is about the 'style' of absurd therapy which really means the style and presence of the absurd therapist and the effect that has on the therapeutic relationship and client's experience of therapy. Adults, perhaps I should say most adults, do become more serious than they were as children. Some perhaps do lose the ability to play but most change the way they play from how they did as children. Adult play tends to be more serious and less spontaneous than the play of children. The idea of adults bringing humour, play, fun and playing the fool into their work may, on the surface, appear contradictory and it would be if done so only in an adult, serious way. For therapists to be absurd in their work, they must first regain much of their 'childishness', in the non-pejorative sense of the term.

Playfulness in therapy has implications for the therapist-client relationship. As discussed elsewhere in this thesis, the nature of power in the therapist-client relationship, as in dynamics of dominance-dependence, varies considerably between different approaches to therapy and between different therapists. There is still a degree of dominance-dependence even in contexts where there is an explicit attempt to equalise the relationship because this will unavoidably arise when one person seeks assistance from another, especially where the latter is identified as having some skill or status in helping others. Presumably, the therapist's power should be benign and channeled into helping clients solve their problems. This has often been likened in the psychotherapy literature as being similar to aspects of the parent-child relationship and therapy as often playing a kind of re-parenting role, especially for clients working through emotional difficulties that stem from their past, particularly childhood experiences.

Child psychologists and some parenting courses often advocate parents being able to enter into and empathise with the child's world of experience, in a sense temporarily suspending their normal adult modes of experience to better understand and communicate with the child. This involves essentially the same process as the therapist empathising with their clients as advocated in virtually all schools of therapy and counselling. For an adult to enter a child's world of experience, they have to shift from their serious reality-based mode into one of play, fantasy and illogicality. This is precisely what the therapist has to be able to achieve in order to

become thoroughly absurd in their therapy sessions, whether with children or adults, as implied in the title of Harold Greenwald's article referred to below: 'Play therapy for children over twenty-one' (Greenwald, 1967). The word "thoroughly" here is meant to differentiate between therapists' serious application of absurdity strategies from therapists simply behaving absurdly in the session. For example, there are many descriptions, in the psychotherapy literature, of the use of carefully thought through and planned paradoxical and strategic interventions, delivered to the client in a serious manner and with a rationale for the intervention provided. Though paradox can be seen as an example of absurdity, in these cases the interventions do not appear as absurd but as logical and reasoned through. The same difference arises from the use of absurdity as a deliberate ploy to get the client to do something, the intervention thereby still being based on reason even if delivered humorously. The differences between reasoned uses of absurdity techniques and being absurd in therapy can be somewhat fine and were referred to earlier, but any philosophical analysis they may merit is beyond the scope of this thesis.

In practice, there is often an effective balance between reason, spontaneity and playfulness in many occasions of the therapist being absurd with the client. Greenwald presents various case vignettes in his article 'Beyond the Paradox' in which he spontaneously behaves quite bizarrely but the reader (and in some, but not all cases, the client) can make sense of why he does what he does. Perhaps this evokes a similar cognitive process as 'getting a joke'.

One time I had a woman who had seen many different therapists. The problem was that she had great difficulty in speaking during therapy as soon as it was so labeled. So I asked her to try to trace it back. (This was analysis.)

T: Did you ever speak?
P: No, not really.
T: Didn't you ever speak to your family?
P: Only at dinner time.
T: OK, instead of meeting in the office, we'll meet at dinner. We'll have dinner out and talk.
P: It wasn't like that. We had this big dinner table and I would get under the table and then while I was under the table, I could talk to them.
T: Why don't we get under my desk and talk?
P: What do you think I am – crazy?

So, I got under the desk, and we had a very good session. She spoke very nicely. The next session she came in and lay down on the couch again. She was not talking so I started to get up and get under the desk. She said, "I'll talk, I'll talk. Just don't get under that damn desk again" (1985, p. 240).

In referring to this same case vignette in another article he adds that she said afterwards, "I guess I've been afraid to make a fool of myself by saying something silly or stupid. But since you showed me that you don't mind making a fool of yourself, why should I?" (1967, p. 45). By modeling playful spontaneity and risk-taking Greenwald is communicating to his clients that they can too. This has to be a genuine communication, not a pretence of spontaneity and playfulness. After describing several similar vignettes, Greenwald adds:

In all of these cases, you might call what I am demonstrating paradoxical; another way of looking at it is as play. I once wrote a paper called "Play therapy for children over 21". I think a lot of what we get out of paradox is that it's a playful approach to life (1985, p. 240).

The challenge is for adults to give themselves permission to be more playful, in the sense of child-play rather than organized play. In this vein and as a playful aside, I developed the following from one of those vagrant e-mails that land on one's computer out of an apparent cyber-nowhere. The origin of this is unknown to me but I have adapted it and added to it.

I WANT TO BE 6 AGAIN

I hereby officially tender my resignation as an adult. I have decided I would like to accept the responsibilities of a 6 year old again.

I want to think the world is fair. That everyone is honest and good.
I want to believe that anything is possible. I want to be oblivious to the complexities of life and be overly excited by the little things again. I want to live simply again. I don't want my day to consist of computer crashes, mountains of paperwork, depressing news, how to survive more days in the month than there is money in the bank.
I don't want to go to the dentist. I want a back that doesn't ache every day and I don't want to know what death is.

I want to go to McDonald's and think that it's a four star restaurant.
I want to sail sticks under the bridge and make ripples with rocks.

I want to think M&Ms are better than money because you can eat them. I want to lie under a big oak tree. I want to see monsters in the clouds and run a lemonade stand with my best friend on a hot summer's day. I want to climb up trees not really sure whether I can get back down just 'cause my friends are doing it. I want to swing on a rope over a creek and sometimes fall in – and think that's funny.

I want to return to a time when life was simple. When all we knew were colours, multiplication tables, and nursery rhymes, but that didn't bother us, because we didn't know what we didn't know and we didn't care. All we knew was to be happy because we were blissfully unaware of all the important things that should upset us.

I want to believe in the power of smiles, hugs, a kind word, truth, justice, peace, dreams, the imagination, the tooth fairy, Santa and every one of his helpers.

So....here's my checkbook and my car-keys, my business cards, my credit cards, my bank statements, and all 32 of my computer passwords and pin numbers. I am officially resigning from adulthood. And if you want to discuss this further, you'll have to catch me first, 'cause, TAG! You're it!

Children laugh and play considerably more than adults and, in relation to paradox, they mostly seem to have no difficulty holding onto mutually contradictory positions, roles, behaviours or beliefs. All of these stand in contradiction to reason, logic and seriousness. So are humour, the comic and playfulness antithetical to reason, logic and seriousness? It is difficult to see how a person can experience the two modes simultaneously, rather that she can only move from one mode to the other, albeit instantaneously. An important aspect of this is that the serious mode is normally linear and goal-directed, in other words there is a reason behind it, whereas with the comic and play, and certainly absurdity, it is the here-and-now of the experience that matters rather than, or at least more than, the outcome. Given that most adults spend most of their time in the serious mode, it should perhaps not be surprising that their too few spells of humour and play appear mostly compromised if compared with childplay. Likewise, play and fun in children arises mostly from their own activities whereas a significant proportion of adult fun and laughter is triggered by external stimuli such as comedy, jokes and entertainment. In my role of psychotherapist, I particularly value the therapeutic potential of absurdity as a stimulus for people to become more spontaneous, less goal-driven and more playful with themselves and others, with their playfulness arising more from within than needing external stimuli. In other words, more akin to child-play than adult amusement.

The point of making these comments here is to emphasise the importance of playfulness, both in terms of therapists' playfulness with clients and the arousal of clients' ability to be playful even in the face of their problems. Humour comes in many different forms that can have very different impacts, not all of which are positive or pleasant, such as when expressing hostility or superiority. In contrast, it can be a means to social bonding, bringing people together in a shared playful experience, promoting empathy and sense of community. It has also been described as a highly adaptive and mature defense mechanism (Vaillant, 1971; Buckman, 1994). The critical difference between negative and positive humour is that hostile and superiority-based forms of humour diminish the other person, which may or may not result in positive feelings for the instigator of the humour, whereas humour as a mature defense mechanism is self-directed and loosens the association between people and their difficulties, allowing them to laugh at themselves and how serious they have been about their problems.

Although the play of children can lead to hostility, and children can certainly be, or at least appear to be, quite cruel towards each other, the concept of playfulness is at odds with cruelty and hostility. When children are cruel to another child it is usually either performed without adequate understanding of the potential harmful effects or their playing has gone beyond being playful. Young children are not yet adequately able to empathise with others which is why legal systems in many countries acknowledge that, up to a certain age, children cannot be held responsible for their actions when being cruel to others, even where their actions have become criminal actions. The legal cut-off age varies between different countries and even between different states within countries. It is usually around ten years of age.

'Playfulness' is a more useful concept than 'play' for the purposes of this thesis. To be playful is to be 'frolicsome' and 'pleasantly humorous' (Macquarie Dictionary) whereas, even with children, play is essentially a purposeful activity and though it can be done playfully, it is not always so. For children, play is a means to act out their experiences and reflections of life and an attempt to make sense of their observations. Children mimicking their parents' arguments or acting out violence they have seen on television are still playing even though the content of their

play appears far from playful. One of the world's best-known and respected child psychologists, Violet Oaklander, described play in the following way.

> Play is the young child's form of improvisational dramatics. It is also more than that. Playing is how the child tries out his world, and it is therefore essential to his healthy development. For the child, play is serious, purposeful business through which he develops mentally, physically, and socially. Play is the child's form of self-therapy, through which confusions, anxieties, and conflicts are often worked through. …… Play performs a vital function for the child. It is far more than just the frivolous, lighthearted, pleasurable activity that adults usually make of it (1978, p. 160).

With adults, 'play' is often used to depict a number of things, such as structured theatrical events or in reference to participation in rule-based games and sports. These forms of play are more often than not anything but frolicsome or pleasantly humorous and games and sport are mostly based on aggression and competitiveness, more akin with dominance-based therapies than the approaches being presented in this thesis as more likely to arise from, or stimulate, therapeutic absurdity. Similarly, an assumption underlying this thesis is that absurdity, especially when playful, is creative whereas reason, at least when unrestrained by non-reason, stifles creativity by channeling thought along lines of consistency and predictability. In the same vein, absurdity tends to be humorous, reason serious.

Playfulness is an aspect of humour that triggers fun and laughter. It becomes an aspect of absurdity when it occurs in circumstances normally associated with suffering or just simply seriousness, when it is 'out of sorts'. Absurdity has the potential to be therapeutic if the serious and the comic cannot co-exist simultaneously in a person's immediate experience, as stated above. This may be the case even in life-threatening circumstances. William Fry (1994, p. 115) relates the story of a man describing an experience he had as part of the WW2 Normandy invasion while heading into the beachhead. The man described everyone in the landing barge as being "scared silly" but continued:

> I don't know who started to laugh but soon we were all joining in hilarious laughter …. laughing our heads off ….. the fright that had possessed us was soon replaced by a wonderful feeling. Had Hitler seen us laughing he would have thrown in the towel then and there."

The therapeutic potential of humour in dire circumstances was vividly demonstrated in the following example from Brian Keenan's book, *An Evil Cradling* (1992) in which he describes his experiences being held as a hostage for five years in Lebanon. The key aspect to the story is that Keenan did nothing premeditated here, in fact nobody had been able to come up with a logical intervention. Considering the dreadful circumstances his behaviour was impulsive and absurd.

I have watched a man lie still for days, his body a living corpse. His face stares back, a pallid mask of the man he was. Nothing will arouse him from his torpor. We are wordless and angry at the constant sight of his silent corpse. We push down our anger, looking to one another to see which one of us might have the energy to go in and find this man and bring him home to us. Our empty faces and our shrugging shoulders display our own fearful anxiety.

I speak to him as if nothing strange is happening and the day is like all the others. "Tell me about bees," I suddenly say without knowing where the thought came from, only that I am now at this instant interested in bees. There is no reply. I speak again to him but know that I am talking to myself, and start pulling from the air of my imagination some facts that I know about bees. I talk about them and ask odd questions that occur to me. Nothing, no response. It's time to find another key. I begin talking about cheese-making. I have always wanted to know how to make cheese, but the subject is boring and my knowledge limited.

I jump from one thing to another, desperately tying together disparate ends to find a way in. "You know what I am going to do when I get out of here? … There is an island just off the north Antrim coast called Rathlin Island. It's a place where in the 14th century Robert the Bruce went to hide out from the English armies. It's the place where he saw the spider. Rathlin Island is sometimes called the disputed island because the Scots claim it and the Irish claim it and the Brits claim it because they claim a part of Ireland. But as far as I know, and its only a small island, nobody has ever found the fucking cave where the spider went swinging back and forward, back and forward, back and forward. I think if I get out of here I am going to hunt all over it till I find the cave and if I don't find one big enough I am going to see somebody with a lot of explosives and blow a bloody great big hole in the side of a hill somewhere and call it the Robert the Bruce Cave, and then what I am going to do is I am going to fill the fucking island full of goats and then I'm going to … No I'm not going to fill the island full of goats, that's ridiculous, 'cause everybody knows about goat's milk cheese and everybody knows about sheep's milk cheese … What I think I'll do is, I'll get a load of pigs, they're cheap, and I'll milk the pigs … When I've made all the milk into cheese I'll put the cheese in this cave and I'll call it Robert the Bruce cheese and make a killing because with everybody disputing who owns this island how can anybody tax me when I start selling the stuff, and nobody will ever have eaten cheese like it before because there is nobody who eats pig's milk cheese."

My own lunacy is beginning to intoxicate me. I am sitting close to the dreaming man. I look quickly at him and see what I haven't seen for days. His eye brightening. Pretending not to notice I carry on ad libbing. "I'll have to make this cheese look different … You know, all cheeses look the same but this being a special Robert the Bruce cheese made on this island, which has never been known before and stored in these caves … I think the French store their cheese in caves but how did it get that funny colour in it? … You know, you get this smelly-sock cheese and its all marbled with blue, well my Robert the Bruce cheese is going to be mottled green 'cause its obviously going to be Irish cheese … Now how the hell do you get all that green mottling in it? … Do you inject some sort of bacteria, or maybe I could get a lot of shamrocks and stick them in it and maybe the bacteria in them would turn it green or something, but then nobody will eat green cheese so I just have to get it mottled the way Danish Blue is. Look at the Danes, they just spread a whole lot of blue ink over their cheese and everybody is buying it."

Laughter beginning to ripple up. Again, I continue, "What are you all laughing at? … I'm deadly serious, this thing could work, think of it … you could make a fortune … Pig's milk cheese, stick Robert the Bruce on it, go to this island, blow a big hole in the wall, who is going to know? Who is going to know if that is Robert the Bruce cheese or not, you get a lot of spiders from somewhere and hang them all over the place; that's your evidence and then how do you get this green stuff into it?" In the middle of the laughter, even the 'dead man' begins to come to life. Suddenly his voice says nonchalantly "You need to bury some copper wires in it, Brian, and after a time pull the wires out; it leaves a green mark throughout the cheese." "Fuck me, how did you know that?"

A man emerges back into life, not because of anything I have said, but the lunacy and the laughter that is at the heart of our life beckon him back and he cannot resist it. There are many things a man can resist – pain, torture, loss of loved ones – but laughter ultimately he cannot resist (pp. 267-269).

Keenan's monologue exhibits a number of characteristics of absurd therapy such as indirectness and metaphor, vivid and bizarre imagery, humorous themes, cognitive pattern interruption, and illogical sequencing of normally disparate themes and images. In therapy these activities can bypass conscious censoring and resistance as well as involve broader client participation, for example through the visual imagery aroused and curiosity about where the story will go.

Numerous themes in Keenan's story can be related to psychotherapy, especially the concept of therapy as liberation.

- He uses a metaphor of imprisonment that mirrors their situation. Therapeutic metaphors tend to be just one step removed from the client's problem, close enough for association to be made but different enough so as not to be a direct comment about the problem.

- He repeatedly refers to future plans once he has moved past the current difficulties. He starts with a tentative "I think if I get out of here I am going to ….. " but moves to confident statements about a future of freedom and adventure: "and then what I am going to do is …. ", "and then I'm going to … ", "What I think I'll do is …". The message is stated clearly that escape is a possibility, albeit to Robert the Bruce Island.
- He enthusiastically conjures up innovative ideas that involve him having power as a contrast to their current stagnant powerless situation. "I am going to see somebody with a lot of explosives and blow a bloody great big hole in the side of a hill" just like they would all like to be able to do right here and now.
- The spider swinging back and forward represents the monotony of their situation and is quite hypnotic in how it is delivered, often a significant characteristic of how metaphors are delivered in therapy. Erickson, notably, used metaphor as the principle component of his hypnosis.
- Further to the previous point, Keenan's delivery of this story is engaging to the point of being quite hypnotic and, in a manner similar to Ericksonian hypnosis, weaves multiple themes into the story which functions both to hold listeners' attention and maintain curiosity while preventing them from securing their own line of thought.
- The story is a paradox of having the ridiculous and serious simultaneously. It is so ridiculous you have to laugh even when at death's door and it even stimulates "the dreaming man" to come up with a solution to the challenge of how to colour the cheese.

Keenan's story also offers metaphorical themes about absurd therapy, such as how engaging the bizarre and comical can be: "but laughter ultimately he cannot resist"; how spontaneity and apparent irrelevance can be made meaningful and relevant; and how the ridiculous can transcend the tragic.

Humorous approaches to counselling and psychotherapy usually include a therapeutic goal to help clients reposition themselves in relation to problems from the serious mode to a comic mode. This involves a shift of perspective to identifying the comic aspects of their behaviour, cognitive patterns, and interpersonal relations. In his book *The Comic Toolbox: How to be funny even if you're not*, John Vorhaus refers to a similar concept as the 'comic perspective', describing

it as the unique ways people look at their worlds that vary from "normal reality" in potentially comical, and often paradoxical, ways. Vorhaus is a professional writer of comic material who conducts lectures and workshops on how to become funnier. He describes the comic perspective as the critical component in comic writing or performance to turn a serious character into a funny one. He believes the simplest effective way to do this is through exaggeration. As described in this chapter and the following chapter, this is also an approach used in paradoxical and humour therapies. In both comedy and therapy this is usually exaggeration of an aspect of the person's behaviour or personality.

> The tool of exaggeration, then, simply takes a comic perspective and pushes and stretches and accelerates it until it's sufficiently far from our perspective to start being funny. A priest's perspective isn't inherently funny, but if you turn him into a perpetual sot, or into the ultimate twinkly-eyed rascal, you start to move him where you want him to go (Vorhaus, 1994, p. 28).

A woman came to see me for therapy because she had become depressed since her husband left her after twenty-eight years of marriage. It became clear that her depression was not primarily fuelled by grief but because for the last few years she had been putting considerable time and money into a series of short-lived relationships with dependent, depressed, aimless, unemployed and mostly alcohol-abusing men. Referring to her as an *Ageing Bo Peep*, I suggested taking in multiple men and calling her home *Mrs. McCullock's* (not her real name) *Nurturing Bosom Home For The Hopeless*. As I continued to advocate increasingly absurd ways she could "console, protect and finance more of these lost souls", she began to both cringe and laugh, often simultaneously, as she increasingly recognised her patterns of self-deprecation and projection of helplessness onto her "flock of losers". Through developing a comic perspective on her recent behaviour pattern, she was able to see the absurdity in it and take action to change it.

Presumably, therapists who have uncovered their own comic perspectives would be better able to help clients do so. One way I help therapists do this is to have them identify and discuss in small groups, usually triads, ridiculous aspects of their own behaviour towards clients in their therapy sessions and then role-play these in the group as exaggerated parodies of themselves. Typical behaviours therapists recognize in themselves during this exercise include becoming too

intense; creating pained facial expressions as a communication of concern or sympathy; barely moving or becoming rigid in the prescribed open, slightly leaning forward counsellor's posture; or saying very little other than "I see" or making reflective grunts such as "uh uh". The comic perspective portrayed here is an over-engaged, self-conscious, stuffed dummy.

Implicit in the above comments is an assumption that as people discover their own absurdity, they can increasingly recognize the absurdities around them and become more able to communicate these absurdities in comical ways to other people. Vorhaus recommends finding a "strong comic perspective" in oneself and then begin to identify strong comic perspectives in others, and the humour will follow.

> People are always asking me how to make a script funny, or a scene, or even a single line. This is true. People even stop me in the supermarket. They say, "Hey, mate, I can tell just by looking at you what a funny guy you are. How can I be funny too?" The answer, as I tell them as I tell you, is to invent characters, invest them with strong comic perspectives and flaws and humanity, exaggerate those attributes, and then turn those characters loose upon the world. Then I ask them if they know what aisle the peas are on.
>
> If you want to be more consistently funny, start building a library of comic perspectives, and start noticing how almost every joke or funny situation you encounter is a function of someone's comic perspective (1994, p. 37).

This is also demonstrated by the examples of stereotypic anchoring labels that can be given to clients, such as *Ageing Bo Peep* and as discussed in the following chapter's section on indirect interventions. Although the labels are used to highlight an individual's absurdity, many of them can be seen to reflect recurring themes in human behaviour, reminiscent of a phrase often used by Frank Farrelly in his training workshops, "what is most personal is most universal" and another from the Monty Python movie *Life of Brian*, Crowd: "we are all individuals!" …… Lone voice: "I'm not".

THERAPIST'S FLEXIBILITY IN USE OF SELF AND RANGE OF ISSUES DEALT WITH IN THE SESSION.

It is easy to imagine that therapists working with absurdity are likely to be more active behaviourally, verbally and in their use of nonverbal modalities such as visual imagery or props. Reason-based therapies are usually centred on talking – mostly the client talking and the therapists quite passively listening. This was especially the modus operandi of traditional psychoanalysis and early client-centred therapy, with the latter often becoming lampooned by its detractors for its reliance on the therapist either simply repeating what the client had just said or, even more simply, occasionally uttering "uh uh".

The requirement for psychoanalysts to be non-interventionist was humorously described by Harold Greenwald in the description of his own psychoanalytic training he presented to the Second International Congress on Ericksonian Psychotherapy held in 1983. Greenwald described how his supervisor held strictly to traditional psychoanalytic tenets and insisted that the analyst was not to initiate any verbal interaction with the client as this would inappropriately influence the flow of consciousness arising from the client. In one case, the client said nothing for half a dozen sessions in the first two weeks of analysis. Greenwald explained to the conference that although he was finding this rather disconcerting, not least of which because he did not feel he was providing the client with an adequate service, he was constrained by the supervisor's insistence that he should not initiate verbal interaction with the client. The procedure in traditional psychoanalysis was to have the client lay on a couch and the analyst to sit behind the client, out of their visual field, silently awaiting the client's flow of consciousness to appear in words and only then for the analyst to offer minimal suggestions, directions or interpretations. Harold Greenwald's frustration eventually got the best of him and he decided to break the rules, figuring his supervisor would not find out anyway as he was not going to tell him. He leaned over the client and asked him "Would you like some help in speaking?" to which the client looked around and replied "Oh, am I supposed to speak here?" Greenwald responded with "Well, that's what most people do".

I have often related that story in professional training workshops to point out that therapists and other clinicians often assume their clients know the 'rules', the procedures, the expectations of whatever strange clinical process they have fallen into, whereas clients mostly do not know the 'rules' especially if they have no prior experience. Greenwald adds a delightful postscript to his

story. After some months of analysis the client reported being much improved and Greenwald asked him what he felt had led to this improvement. His response was that the best part of analysis had been the sessions in the first two weeks when he had not talked but had to face himself in silence.

Greenwald describes the sense of liberation at the time he discovered he could much better join with his client through being animated and spontaneous in the therapy session rather than adopting the distance and formality his training had been requiring of him. In so doing, he had to move away from psychoanalysis.

> Up until that time, I thought you had to be grim all the time and that was a terrible strain on me. I would be so tired from hearing so many funny things without being allowed to comment on them; I certainly wasn't allowed to laugh. Joining made a big difference for me (1985, p. 238).

From his description in an earlier article, Greenwald's process of becoming more spontaneous and playful may be seen as paradoxical within the confines and expectations of orthodox psychotherapy and the usual goals of professional training. As an inexperienced therapist undergoing training and supervision in 'institutionalised' psychology and psychotherapy, he had to present himself to clients behind a persona of serious professionalism. As he matured in his profession he was able to return to what he saw as his more natural (untrained) way of interacting with people.

> As a beginning therapist I tried to be serious, thoughtful and understanding. Like many beginners I found myself becoming increasingly grim and super-serious. Even worse, I found myself to be going against my own nature so that I found my work exhausting and debilitating. Fortunately as I began to become more confident of my craft I returned to my more normal state of being and discovered ways of making my naturally playful disposition useful to my patients (1967, p. 44).

I can relate Greenwald's descriptions to my own experience of training as a psychiatric nurse during the 1970s in a large psychiatric institution in Melbourne, Australia. Orthodox psychiatry generally provides a barren environment for clinicians to allow themselves to relate to clients from a "more normal state of being" and "naturally playful disposition". One thing that stood

out for me in my early psychiatric training was, despite the undeniable amount of suffering (as much from the treatment as from the psychiatric disorder), how funny, at times hilarious, and innovative patients would often be – and often know they were being.

A teenage girl had been admitted into the locked admission unit where I was working. This was her first psychotic episode and first experience of a psychiatric institution, as it was also for her parents who were ringing the doorbell of the huge metal Victorian door at the end of a very unfriendly echo-filled white corridor. I unlocked the door and they slowly edged their way in, clearly quite terrified by the prospect of entering a madhouse. As I am trying to reassure them that they are in no threat and that their daughter is looking forward to seeing them, a very large man appeared at the far end of the corridor and, seeing new faces, proceeded to run towards them. The sounds of his big feet pounding on the floor reverberated throughout the corridor. The girl's parents pressed back against the wall, hoping it would swallow them up before he did. Screeching to a halt right in front of them, he reached out an enormous hand in greeting and shouted, "G'day, I'm mad Bill from Broken Hill. I've never worked and I never fucking will!" and with a frantic shake of the stunned father's hand, he twirled around and ran away.

On my first day in a locked back ward housing mostly 'criminally insane' patients, of whom a number had committed murder but 'sentenced' to the psychiatric hospital. One of these had been given the nickname *Mr. Ripper*, due to the nature of some of his criminal activity, and was renowned for inflicting an initiation test to new staff in the ward. I had been warned about this and advised that he stood by, and defended, those who passed his test but made time on the ward a nightmare for those who failed. My first encounter with him, and, as it turned out, his test, was to pass each other in the corridor and, with a threatening stare, he blow out a considerable amount of nasal content into his hand and wiped it through his hair. All or nothing here, I thought and said, "Run out of Brylcream have you?", gulped and kept walking. His guffawing let me know I had passed his test.

These examples of spontaneously absurd but socially-oriented behaviours by patients stood, in my experience at least, in contrast with how serious, even grim, many of the staff were. I witnessed many staff members, including psychiatrists, fail *Mr. Ripper's* tests. During one of the

weekly ward general meetings, attended by all patients and on-duty clinical staff, the psychiatrist running the meeting noticed that chain-smoking *Mr. Ripper* was dropping his lit cigarette butts into his half-full cup of tea. He had dropped in a half dozen butts by the time the psychiatrist loudly stated: "Mr *(actual name)* that is a cup of tea not an ashtray, you are supposed to be drinking it not dropping your cigarette butts into it." He put the cup to his lips and slowly swallowed its entire contents while staring intensely at the psychiatrist throughout, who, obviously disgusted, closed the meeting and retreated to her office. In contrast, most of the patients and a couple of the staff sniggered or laughed as he emptied the cup.

Having to remain passive and always serious throughout individual interviews, group therapy sessions and ward rounds seemed artificial, was often frustrating for clinicians and patients, and was on the whole ineffective and unproductive, and disrespectful or even potentially harmful, to clients as in the following example. I recall a psychiatric hospital inpatient being brought into a room in which at least a dozen clinicians were seated in a half circle. He was seated facing this mass inquisition and the chief psychiatrist asked him various questions to which his replies ranged around messages from Alpha Centauri that were being transmitted through a local radio station specifically to him, CIA plots to vacuum out his brain for implantation into their agents, and nuclear powered remote-controlled worms living in the walls of his hospital room. For twenty minutes a dozen or so professionally trained and reasonably well-paid people sat looking blankly at this young man as he poured out his amazing ideas and not one of us could permit even a smile. Some of us wanted to. I did, in fact I was digging my teeth into the inside of my lower lip to stop myself bursting into laughter. I felt sorry for the lad but found what he was saying to be hilarious. Eventually the 'victim' was escorted out of the interview room and as soon as the door closed many of us did let loose with our laughter and even the more serious members of this esteemed gathering, including the chief psychiatrist, permitted themselves a chuckle. It did occur to me at the time that the room was not sound-proofed and the patient would have heard our laughter. He was diagnosed as paranoid schizophrenic.

Sitting silently and seriously while listening to someone speak nonsense, at least nonsense to the listener, seems rather artificial to me. Even sitting silently and expressing little or no emotional response while someone is talking about painful experiences, as occurs in many serious therapy

sessions, seems artificial. In the same vein, carefully and logically analysing every aspect of what somebody is saying, without expressing any personal emotional response, has also struck me as somewhat peculiar, but this is a common therapist behaviour. I have made similar comments to this in gatherings of psychotherapists, psychologists and psychiatrists and the most common reactions are along the lines that it would be unprofessional, disrespectful or "countertransference" (displacement of one's own emotions onto the client) to do otherwise. Imagine how taken aback and intrigued therapists can be when they come upon the idea that being natural, emotionally responsive, and able to play with the complexities of their clients' worlds might not be intrusive or inappropriate but empathic and possibly even helpful.

> It was quite a surprise when I found that the use of paradox was a "technique". Members of my family had always communicated in this manner. So I was happy to find out that it was a technique and I was "allowed" to speak with patients in the way I usually spoke at home without having to cloak myself in the fictional sincerity of the therapist (Greenwald, 1985, p. 237).

A frequent observation made both by clients and therapists is that sessions containing absurdity, especially humour, playfulness and nonverbal activities, are usually livelier than sessions involving predominantly rational verbal processing of information. This applies not only in therapy but in most if not all communicational contexts involving absurdity. Some of the exercises in my workshop require participants to conduct serious verbal counselling with their client (also a workshop participant) for a few minutes and then instantaneously shift into an absurd mode for the same number of minutes. At the shift to absurdity the interaction within the dyads immediately becomes more intense, louder and more nonverbally overt. After the exercise, participants always report different temporal experiences of the two halves, with the second half seeming to pass much more quickly.

As already pointed out, reason, rationality and reasonableness imply "sensible conduct", "moderation", and "not exceeding limits prescribed by reason". Reason is methodologically linear, moving from one point to the next in logical sequence. It should not deviate from the prescribed track if it is to be "defensible on the grounds of consistency". Reason is essentially

intellectual and is often contrasted, usually to imply superiority, with emotion and concepts such as intuition, impulse and spontaneity.

Absurdity, on the other hand, is "out of harmony with reason or propriety", "opposed to reason, received opinion or common sense", "obviously false or foolish", "comical, laughable". It is also described as "conflicting with preconceived notions of what is reasonable or possible". Chapter 2 explored these implications further, particularly in relation to reason and absurdity as means to influence change. The discussion in this chapter is concerned with how these differences influence the behaviour of therapist and client and nature of the material worked through in the therapy session.

Absurdity is often unpredictable, surprising, baffling, arising spontaneously and usually arousing emotional reactions, confusion, perplexity and laughter. It tends to arrive as much through nonverbal imagery and behaviour as with words. Reason occurs mostly through verbal and intellectual means, absurdity tends to occur through a broader range of channels and stimulates a broader range of reactions than verbal and intellectual ones. This perhaps can be translated into the claim that the more absurd therapists become, the more they will use what is available to them – that is to say more of themselves, not only their intellect and language, and more around them, such as humorous props – and the more they will be able to elicit from their clients. It would be a fair claim that absurdity leads therapists to use more resources in their therapy, but more debatable whether or not this then elicits more from their clients. On the whole, therapists who bring absurdity into their sessions describe themselves as becoming more spontaneous and flexible; working with clients more intuitively; being more present-centred, responsive and playful with the client. This is common feedback I have heard from therapists who have participated in my humour therapy workshops. The therapist is also modelling these behaviours and attitudes to the client.

Farrelly argues that, to be effective in gaining rapport with clients and then eliciting affective reponses from them, therapists have to be flexible in their use of language and nonverbal behaviour. He advocates that therapists should allow themselves to "talk in a much more gutsy, affectively charged, connotatively loaded language" because "the kinds of things clients are

struggling with are to them emotional dynamite; their conflicts do not fit into polite, socially correct terminology" (1974, p. 120). Therapists working with adolescent clients tend to recognise the importance of being able to "speak their language", though without becoming transparent with this. Similarly, to be prepared to match the client's nonverbal behaviour to some degree can influence rapport and improve communication. Being 'stiff' and formal with a teenager just might prove to be an obstacle to therapy while being 'loose' and casual with a conservative middle-aged bank accountant could jeopardise that relationship too.

Farrelly defends the therapist's use of "locker room language", responding to the question of whether or not this is 'professional' with:

> Our response is that the term "unprofessional" should only be utilized when it can be shown that such behavior is detrimental to the goals of a given profession – in our case to the welfare of clients – and not as a substitute for "naughty" or "I don't like it." It seems abundantly clear to us that it is merely an institutional definition to assert that words with Grecian and Latin etimologies *(sic)* are considered inherently more "professional" than Anglo-Saxon slang words for bodily functions, organs, or behaviors (1974, p. 127).

> Furthermore we use language like this with friends, families, and colleagues; and patients use language like this among themselves and to staff. Why not then use this language and match theirs if it is effective? Because we desire to *provoke an affective* experience in the client (both to sensitize as well as desensitize), we try to avoid substitutional euphemisms and bland terminology when talking with them (1974, p. 127).

The point seems to be that a therapist's preparedness and ability to be flexible, creative and responsive to the particular client's own approach and style, probably correlates with how engaging and potentially effective their presence will be. At a simple level, a psychotherapy client needs to have a sense that their therapist is able to relate with them and be capable of a sufficient amount of understanding of what their life is like for them. Most psychotherapists, and most other professionals and non-professional helpers dealing with people coming to them in some sort of need, are confronted by people from all sorts of socio-cultural backgrounds. In this case, flexibility is surely an asset whereas rigidity, or limited range of responses – especially where they are prescribed by a particular school or code of practice – is potentially an obstacle.

This is not to say that all codes of practice are inappropriate. By design they are limiting but in some cases the intention is to protect the client from potential abuse by the practitioner. Prescriptions that potentially limit the possibilities and effectiveness of therapy, that are based on ideology rather than protecting clients, such as with Greenwald's psychoanalytic training, are usually framed within the bounds of reason - a well-thought through rationale. This is where reason can become suffocating, not only putting the therapist into a vacuum but possibly limiting what might have been achievable for the client in therapy.

To leap into absurdity requires courage and a fair amount of 'cheek', especially for a therapist who has been trained to maintain seriousness and reasonableness throughout all therapeutic encounters (as most have, particularly psychologists and psychiatrists). It takes courage to move beyond the traditional therapist comfort zone of the open-postured seated position, serious though fully attentive facial expression, and with few but (supposedly) always relevant words. Absurd therapists get out of their chairs, such as Harold Greenwald clambering under his desk during a therapy session as described earlier in this chapter in 'Playfulness and Humour in the Session'. They clown, parody and play the fool, displaying a wide range of nonverbal behaviours and sometimes appearing to be *not* attending to the client or even deliberately ignoring them.

For the therapist to be truly absurd, this courage is also to consider all (or almost all) topics as fodder for therapy: take on all comers and any topic; and in so doing be unreasonable and ridiculous – "out of harmony with reason or propriety" – with whatever arises during the session. The ability to do this empathically with others arises from, or is at least enhanced by, a preparedness to do it to oneself and to allow others to do it to oneself. In other words, if therapists are to consider nothing, or very little, about clients' lives to be 'out of bounds' in therapy, and if they are willing to emphasise the absurd aspects of clients' lives, they surely must be willing also for themselves to become the 'butt of the joke'. If I am unable to see, and laugh at, my own absurdity, and also laugh along with others as they point out my own absurdity, my focussing on others' absurdity will be at risk of becoming destructive of them. This relates to the superiority aspect of humour in which I laugh at other people when I see

them as somehow inferior, at least during the humorous event. Humour and absurdity then become power-based, not egalitarian or liberating.

Vorhaus portrays this ability as a foundation for becoming a good comedian. He calls it "the will to risk" and his suggestions on how to develop the will to risk are, probably unknown to him, good examples of therapeutic absurdity, such as poking fun at your flaws; welcoming your "ferocious editor"; and exaggeration, which comic tool he states "requires above all else that you be bold" (1994, p. 28). As discussed in the previous section, Vorhaus urges his readers to develop a "strong comic perspective" by identifying major comic themes in their lives, which is also one of the goals for clients frequently identified by practitioners of humour therapies.

According to the exponents of paradoxical approaches to therapy, so-called 'resistance' in clients, something usually feared by trainee therapists, should be welcomed by the therapist as providing energy to the session. The secret, they say, is to join with it, not fear it or oppose it. Some ways to do this are described later. Joining or flowing with resistance rather than opposing or fighting it, in therapy, has been likened with the same principle taught in martial arts such as aikido and judo.

> The context of Aikido is one in which a person, or persons, approaches the Aikidoist with an intended challenge (attack). By his actions the challenger is stating: "I am challenging you to deal with me and to try to change me - I'll prove that you cannot and that I am more powerful than you". The Aikidoist perceives this challenge not as a competitive or conflictual one, but rather as an 'opportunity' both to learn about and teach the challenger more constructive and harmless ways of asserting his energy…….Similarly, a client approaches a therapist with a comparable, often unconscious, challenge, as if to say, "I am challenging you to deal with me and to try to change me - I'll prove that you cannot and that I am more powerful than you"…….the brief strategic therapist also views himself as a teacher whose function is to help the client, as briefly and harmlessly as he can, to find more constructive interactions in which to engage his energies (Saposnek, 1980, p. 228).

This challenging or resistant behaviour may not be universal in therapy, though some therapists consider it to be so. This view is probably nowhere more strongly stated than by psychotherapist Frank Pittman (1978, cited in Saposnek, 1980, p. 228): "People come to therapy in order *not* to change….If they wanted to change they wouldn't come to therapy." This is

perhaps too much of a generalisation but not uncommon all the same, as therapists working with adolescents, couples and families, eating disorders and substance abuse will vouch. Interestingly, these are areas with which paradoxical approaches have been found to be particularly effective and many of the paradoxical strategies used today were originally developed in family therapy contexts.

NONRATIONALITY IN THE SESSION, THE THERAPIST APPEALING TO 'UNCOMMON SENSE'.

Dictionary definitions of absurdity include that it is "contrary to reason or common sense" and "conflicts with preconceived notions of what is reasonable or possible". A therapist can introduce absurdity into sessions when clients' reasoning or usual cognitive processing is either maintaining their problem or preventing them from conceiving solutions or new ways to deal with it. The old thinking may have been unreasonable in one sense of the word (harmful, unfair, not based on good judgement) but to have persisted with it, however unpleasant the consequences, has given it a personal sense of reality. People can always give reasons (both to themselves and to others) why they are so bad or so unworthy and can provide themselves with compelling evidence that others share this view of them. A frequent presentation in therapy, it becomes a person's common sense and self-perpetuating cognitive-emotional-behavioural reality: a vicious circle of self-defeating thinking leading to behaviours that reinforce the thinking and so on. It may be unreasonable but it has become the person's reality all the same.

Rational therapists would point out to clients the irrationality of their thoughts and behaviour and take them through steps to replace the old thinking with rational thinking. This might involve rejecting old premises from which the old thinking had led to the previous damaging conclusions, such as "I am worthless (premise), therefore no-one will approve of me, therefore my whole life is worthless". Rational therapists would try to help clients redefine themselves by examining evidence that the old premise is incorrect and finding evidence to support a new premise that "I am worthwhile". The content of the old thinking is challenged but not the basic principles of reason on which it was based.

Numerous therapists who work with absurdity have described their antics to me along lines of prodding clients outside the boundaries of their old cognitive style to open up opportunities to look at and tackle their problems in new ways. I often relate to clients the old cliché "if you keep doing what you've been doing you'll keep getting what you've been getting" and then add "if you keep thinking what you've been thinking you'll keep doing what you've been doing…". This cliché reflects one of humankind's great behavioural absurdities that, so much of the time, we persist in thinking, doing and getting the same things however useless, unhelpful, damaging or self-defeating they may be. This absurdity occurs at the level of individuals and at the socio-cultural level. Arising from this is another great absurdity that, more often than not, when people do attempt to find solutions to problems they tend to do so repeatedly with the same, or variations of the same, methods that have previously failed.

The evidence seems to be that people, at the individual level but also at the socio-cultural level, often do not learn from their mistakes. The challenge, then, is to find ways to trigger cognitive leaps in oneself, or in others (as therapists might attempt to do with clients), that may stimulate creative approaches to solving problems and changing behaviour patterns. This is in the spirit of Einstein's famous statement "We can't solve problems by using the same kind of thinking we used when we created them".

Farrelly describes how after 91 therapy sessions trying unsuccessfully to reason with a psychiatric inpatient (pseudonym 'Bill'), he threw out the rule-book and launched into the absurdity of agreeing with Bill's self-negating and hopeless thinking.

> I had been essentially communicating three basic ideas to him: 1) You are worthwhile and of value; 2) You can change; and 3) Your whole life can be different. He, in turn, had been persistently communicating back to me three complementary responses: 1) I am worthless; 2) I'm hopeless and can never change and 3) My life will always be one long psychotic episode and hospitalisation. It was becoming increasingly clear that empathic understanding, feedback, warm caring, and genuine congruence were simply not enough and were getting us nowhere. At this point I 'gave up' and said to him, "Okay, I agree. You're hopeless. Now let's try *this* for 91 interviews. Let's try agreeing with you about yourself from here on out."

Almost immediately (within a matter of seconds and minutes, not weeks and months), he began to protest that he was not *that* bad, nor *that* hopeless. Easily observable and measurable characteristics of his in-therapy behaviour started changing. For example, his rate of speech markedly increased, his voice quality changed from a dull, slow motion, soporific monotone to a more normal tone of voice with inflections and easily noticeable affect. He became less over-controlled and showed humor, embarrassment, irritation, and far more spontaneity. In a very embarrassed tone, he spoke about his "regressing" (a favorite, central term in his emotional lexicon) but felt that I had been of great help to him. I replied, "Help? Hell, I started seeing you a year and a half ago on a locked, closed ward, then you moved out to an open ward, then you got discharged from the hospital, and now here you are, back again on a closed, locked ward. Well, if I've been of any help to you and you're showing any kind of progress, you're moving with all the speed of a turtle encased in concrete."

He became red in the face and stated that I shouldn't expect too much too soon from him: "It'll probably take me two or three years resting up here before I get out of the hospital." My heart sank down to my liver, but I disregarded my affective response and blandly replied, "Yeah, I can see you now, as we go on and on towards the second 91st interview. You'll probably "regress" more and more as you keep saying, until I'll be feeding you your Pablum like a tiny baby." Then in a coaxing voice I added, "Come on Billy, Take your Pablum." He blushed beet red and burst out laughing. I continued, "Then you'll probably lose control over your bowels and bladder (he again blushed furiously and laughed explosively), and I'll have to change your diapers, which we'll have to make up out of bedsheets because you've got such a fat ass, until finally by the time we reach the next 91st interview you will have made medical history." The patient looked puzzled and asked cautiously, "What do you mean?" I answered, "Well, hell, Bill, if you can continue this 'regression' like you keep saying, by that time you'll be the first neonate on record with pubic hair.

I further implied wearily that he probably was right, that he probably would spend the rest of his life in a mental hospital. Six interviews later he got himself discharged. When he returned a year later, I immediately went over to his ward, walked into the dayroom where he was seated, and with an expansive, open-armed gesture, chortled loudly that my prophesy had come true: "Just call me Frank Isaiah Farrelly." In two weeks he fled and has not been seen since (Farrelly & Brandsma, 1974, pp. 26-27, author's italics).

The absurd therapist is not restrained by the demands of logical and mature behaviour or cognition and, at times might present as more un-reason-able or even 'crazier' than the client. Some years ago I was presenting to a group of psychiatric interns and registrars an ex-client who had benefited greatly from psychotherapy, much of which had involved humour. One of the doctors asked the client what she felt it had been about the therapy that had most contributed to her recovery. I intervened and began to explain that, as this client's problems had been

numerous and the therapy consequently complex and lengthy, it was unrealistic to identify one aspect of the process that would have been most important. At this the client exercised some of the assertiveness she had discovered in therapy, told me to be quiet and stated there was one thing that stood out for her. She explained that she had seen a variety of counsellors, social workers, psychologists and psychiatrists over the previous few years, without experiencing significant improvement to her condition, before being referred to me. What had made the difference? Calmly she looked at the dozen faces before her, glanced at me with a pretended wry grin (a trick she had learned in therapy!), and stated "'After suffering years of boring bullshit I finally got a therapist who was weirder than me and not only could get away with it but was making a living out of it".

Absurdity can be a means to lampoon the idea that there can be a single, correct truth or explanation. To do this, the absurd therapist might ignore, interrupt or overwhelm the client's intellectualisations and rigid theories; lampoon the client's "why" questions with ridiculous explanations; enthusiastically debate various conflicting rationalisations, explanations and theories portraying them all as true and false simultaneously; or simply present one explanation for the client's behaviour during the session, a different one the next and yet another in the third session. The client objects: "But that's not what you told me was the problem last week." The therapist responds: "I've changed my mind."

In some absurd therapies, such as provocative therapy, the therapist can be like a dog stubbornly holding onto a stick, refusing to let go of absurd interpretations or caricatures even after the client has achieved their goals or desired changes, as in the *Weird Left Tit* case described by Farrelly and quoted below. This tactic is seen as helping clients 'set their changes in concrete', becoming self-affirming and assured in defending and maintaining their new position. The provocative therapist keeps 'playing the fool', deliberately 'losing' the debate about whether or not the client really has improved.

A young woman was referred for therapy who had a variety of problems in both task performance and relationship areas. She was gradually able to achieve much better in her work but still continued not to date. She finally confessed with some embarrassment that when she was a young girl and her breasts began to develop, she went to

her mother and told her about her problem. The problem was that, though her right breast fitted her bra, her left breast "rattled around like a goober pea in a fuel oil barrel". Her mother took her to her family physician who took the bra off the frightened young adolescent, looked first at one breast and then at the other and issued this dictum, "This is not an uncommon phenomenon". She then was told to dress and return home. Horror struck, she felt that she had a combination of leprosy, polio, and various venereal diseases. When she began to date boys, she immediately ran into the problem about their wanting to pet; her response was simply to avoid the situation and, as a result, she usually had only one or two dates with each boy.

T(herapist): You mean you're embarrassed and ashamed for them to find out that you've got that weird left tit?
C(lient): (*Embarrassed, hanging her head.*): I don't like the way you put it but, yeah, that's about it,
T.: So that's why you've been avoiding half the human race! (*He pauses for a moment.*) Well, hell, now that I think of it, your behavior makes sense. Because if you were to go out on dates with guys – guys, being guys, would naturally want to pet and get all they could off of you (*the client nods*), and once they got your blouse open, there could only be three possible reactions that a fellow could have toward you.
C. (*Curiously but simultaneously embarrassed.*): What are they?
T. (*Very seriously.*): Well, one reaction would be that he would hastily button up your blouse and say in an embarrassed manner, "I'm sorry, I didn't know you were a crip." A second reaction might be that he would get all heated up and say, "Whoopee, I've always wanted to do it to a crip!" And the only other possible reaction that a guy could have would be that, once he had unbuttoned your blouse, he would stare at your weird left tit and exclaim, "Hold it right there will ya? Let me get my polaroid swinger – the guys back at the frat house will never believe it when I tell them."

The patient stared at me throughout this and finally with a weak grin stated, "Yeah, that's what I feel would happen, but I'll never really find out if I just sit here and talk and talk about it with you." I got anxious at this point but told her that time was up and that we'd have to discuss it further the next time. As she was about to leave I remarked, "I like to name my interviews, so I thought I would call this "The Weird Left Tit Interview." She laughed and said, "That sounds like an appropriate title for it."

The next interview she came in looking like the cat that had swallowed the 400 pound canary. I greet her with, "Well, Gorgeous, what the hell have you been up to since I saw you last?" Quite briefly, she explained that she had gone out and, with much fear and trepidation, had "hustled" a guy and had gone up to his apartment with him. They had shed their clothes and, while in their birthday suits, were having fun and games. Right in the middle of the proceedings she called his attention to the fact that her left breast was smaller than her right one. His response was to look at one and then the other and give a client-centred response: "Oh, yeah, you feel it is, huh?" and immediately resumed his activities. She felt like an immense, eight year old lead weight had suddenly been lifted from her shoulders and she experienced a marked sense of relief at his acceptance of her.

T. (*Disgustedly*): So you went out and lost your virginity, huh?
C. (*Grinning*): I lost everything but my technical virginity, but it was worth it because of what I learned about myself.
T. (*Protesting*): Well, hell, Dum-Dum, you just ran into a sex maniac. You can't predict other guys' responses from *his* response to you about your weird left tit. You just wait and see – the next guy will run screaming from the car or bedroom when he sees it.
C. (*Looking at the therapist with patience and with assurance.*): Well, then, I'll just tell him as he runs away, "Lots of luck, fellow, on your fruitless quest for bodily symmetry."

And that, we submit, is a beautiful, integrated response (Farrelly & Brandsma, 1974, pp. 67-69, author's italics).

Disregarding, and perhaps also bouncing off, the therapist's protestations, which were essentially a 'take-off' of the client's earlier fears, this client appears to have found, and consolidated, a new attitude towards herself without therapy ever actually addressing those fears in a systematic or overt way. By reframing the client's fears into a bizarre scene portraying the other person's reactions (the guy rushing off for his polaroid) as absurd, the therapist may be jolting the client out of her previous 'common sense' that she was a freak into a new perspective that the guy is the freak, or at least misguided.

THE THERAPIST'S USE OF INDIRECTNESS AND IMPLICITNESS.

To apply reason to problem-solving, in therapy at least, the problem is first identified and clearly stated and then a desired reasonable outcome identified to be methodically and directly worked towards. The process consists of logical steps progressing directly towards a premeditated goal. For example a CBT approach to agoraphobia typically will involve some or all of the following steps:

- Clients are provided with psycho-education about the nature of agoraphobia, anxiety and the mechanisms of panic attacks and then taught how to manage panic attacks.
- They are taught progressive relaxation, visualisation and instant relaxation techniques.
- Fear/anxiety situations are identified and graded into a 0-100 hierarchy from low anxiety (5-10) to extreme fear (90-100).

- Cognitive components of anxiety behaviour and anxiety-avoidance behaviours are identified and challenged with the aim to stop, diminish, "restructure" or replace them.
- Fear situations in the hierarchy are faced, either in reality or through visualisation, from the low anxiety arousing progressively to high anxiety arousing. Clients practice their newly learned cognitions and behaviours while facing each fear.

In contrast, absurdity tends to be all over the place, inconsistent, illogical, out of tune, without rhyme or reason, out of step. Any goal, if there is one, appears to be about the here and now rather than something attainable through organised, sensible progress. If an outcome is to be achieved, it is not via the direct and obvious route. Given this, the absurd therapist will often appear not to be directly addressing the problem or goal, sometimes appearing to be moving away from it, perhaps asserting that the problem is not really a problem, even appearing to blame other people for it, talking about anything and everything other than the problem, or weaving stories about fictitious characters or (fictitious – perhaps!) ex-clients who just happened to have similar problems to this client. On the other hand, the absurd therapist might focus directly on the problem by exaggerating it, perhaps taking it to bizarre but vivid extremes. An example of this is the *Gore Galore* session described in the next chapter.

I have found a linear reason-based therapeutic approach more often than not to be sufficient in helping people overcome simple, specific phobias but often insufficient in the treatment of more complex or profound phobias such as agoraphobia, social phobia and phobias involving high levels of anxiety and avoidance behaviour. In my experience the most effective treatment of these conditions has involved a combination of rational and systematic therapeutic strategies with absurd interventions. It is certainly useful for a person suffering panic attacks to learn how to control them through breathing, positive self-statements and relaxation techniques and the easiest way to do this is through systematic learning and practice. The treatment of agoraphobia provides an example where absurdity can co-exist with reason, such as in heightening clients' experiences, making them more vivid and memorable, and shocking them into radically different perceptions of their anxiety stimuli and of their ability to cope with these. Two creative and effective examples of absurdity with agoraphobia are paradoxical intention, described in the 'prescribing the problem or symptom' section of Chapter 6 and the clown balloon suits

described in the 'dressing up' section also in Chapter 6. I also use anchoring labels and 'naffirmations', also discussed in Chapter 6. For example I labelled one chronically agoraphobic client "Ms Wobbly Socks" and asked to repeat, ten times before and after a potential panic attack (while breathing slowly) "I have the power to perceive even the most trivial situation as a gut-wrenching, heart-leaping catastrophe".

The indirect approach can be particularly effective with clients who have become over-focused on their problems to a degree that disables them from being able effectively to deal with them, locking them into predictable (as in self-perpetuating) but self-defeating cognitive and behavioural patterns or vicious cycles, and often leading to 'musturbations' and 'demandments' as described in the following chapter. The therapist's absurdity distorts and often interrupts clients' disabling flow of flawed reasoning, at least leaving them disoriented and not so focussed on what they have been defining as their problem. Absurdity and reason can both occur within the same session, such as when therapist's absurdity interrupts the client's cognitive pattern to leave the way open for an emergence of new, more adaptive reasoning – perhaps even reasoning suggested by the therapist (in a reasonable manner of course). The therapist appears to have been absurd and then reasonable and might even become absurd again, perhaps as a stimulus for the client to re-assert and strengthen the newly arrived at line of thinking, as in the following case vignette from one of my family therapy sessions to which I gave the title *You're just not being reasonable!*

This was the first session. The family was a professional couple in their mid-40s and their fifteen-year old daughter, their only child. The mother had made the appointment. Both parents appeared quite exhausted and exasperated with their daughter who, in turn, sat with arms tightly folded, looking down to the floor or out of the window to avoid eye contact with everyone in the room, and for the first half hour of the session remained silent and tight-lipped. The parents' complaints about their daughter, which will be familiar to many parents of adolescents, included:

- "She stays out too late at night for a girl her age. God knows what she gets up to. I know she hangs around with older boys but she refuses to listen to us about safe sex and drugs."

- "She uses the home as a hotel. She does nothing to help around the house. Her bedroom is a disaster zone. She stuffs her dirty clothes under the bed until the room stinks."
- "Whenever she has any money she spends it immediately on CDs, weird clothes and trinkets but contributes nothing to house-keeping and never buys anything sensible. Even when she admits she needs something she just pleads poverty and assumes we'll buy it for her."

I attempted for a while to engage the daughter but as she steadfastedly continued to refuse to talk, I maintained a discussion with her parents about her behaviour, eventually asking them what it was they were wanting from her. When they had listed a few desired behaviours, I turned to her and asked gently what she though about her parents' list and if she thought they were being reasonable. The daughter, no doubt, was assuming that I would be supportive of her parents' list and expecting that I would try to help them find ways to coerce her into moving towards adopting some of the items. Seeing the usefulness of now defending herself she decided some engagement was appropriate and muttered something about them not understanding young people these days, that things were different these days and young people are more independent and free-thinking than when her parents had been young, and that they needed to learn to trust her more and realise that she was mature enough to figure these things out for herself without them always interfering. This was obviously familiar territory for the parents who, with 'we never win this battle' expressions, looked pleadingly at me for support while their daughter sat back defiantly satisfied that she had once again forcefully asserted her position and exposed the flaws in theirs.

Much to everyone's amazement, I enthusiastically leapt to the daughter's defence, proclaiming her logic to be watertight and that in her own struggle against misguided and obsolete parental moralism she stood for an entire generation of misunderstood, distrusted and terrorised teenagers. I pointed out to her that this was an enormous responsibility to have taken on, congratulating her for having the courage and endurance to have done so. I added that she was failing in her mission in one crucial way which was that she had not yet succeeded in crushing the opposition as they were still coming up with counter-arguments, however defunct and unreasonable they might be. As the transcript of what followed is too lengthy to include here I

will just provide a list of the main points in my apparent support of her position. The points are presented here in the order as I made them and basically in the words I used as I noted my comments down immediately after the session. It can be seen that my defence of her position became increasingly outrageous, though still based on her own premises. As the points became more outrageous, my nonverbal behaviour became increasingly a burlesque of her own communications of indignation and dogmatism.

- "What would these old fogies know about the incredibly complicated lives young people have to grapple with these days? In their days there was never more than a handful of LPs to choose from whereas these days ….. I mean how many CDs are you wanting right now but can't afford because they won't give you the money? I bet all your friends have them all by now."
- "And what about the jewellery? You gotta look these days or forget popularity and guys. Once oldies get married they stop caring about how they look so how would they know anything?" At this point I spent a while chatting with her about the jewellery she was wearing, asking how much things cost, complimenting her on her good taste, betting her girlfriends were jealous, and so on.
- "Bedrooms are for being comfortable in, listening to music in, hanging with girlfriends in so what's with this neatness shit? And what's wrong with shoving dirty laundry under the bed. Isn't it just the same as putting it into a laundry basket. At least you're putting it all in the same place so it's easy for mum to find it. Actually it's better under the bed so no-one gets to see it like they would if it was piled up in a laundry basket. I think you're being very helpful putting it all in one place for mum and considerate keeping it out of sight like that!"
- "When they were kids they probably had to be in bed by ten 'cause that's what they were like in those distant times past. These days it's all about all-nighters. Shit every fucker's doing it – whoops sorry, wrong word, you're not actually fucking yet, or are you, anyhow that's none of anybody's business. You obviously know everything there is to know about fucking. You talk about it with your girlfriends and between you all you'd have a collective knowledge of everything there is to know about fucking, and what guys do, and how they think, and how to turn them on, and how to stop them going too far,

and how to make sure you don't get pregnant, and what to do when you do get pregnant when you didn't want to …(etc.)."

- "Now I think of it what's so bad about having a baby at fifteen anyway? Look at you, you are a woman now, well a baby-woman but woman enough to have a baby. Then you'd be able to get more money. You could get money from the government if you have a baby. And your parents wouldn't hold back their money 'cause they'd be worried about the baby. You could just drop it off to them for its meals while you go out with your friends and buy CDs and clothes and alcohol and jewellery and stuff like that. They're not going to let a little defenceless cute baby go hungry like they might let you go hungry."

Initially the daughter was hooked by my enthusiastic though overstated presentation of her arguments. She would jump in alongside me re-asserting her case even though its basic flaws and unreasonableness were increasingly being exposed, not by attacking it but by taking it to its extreme. Eventually my comical exaggeration of her arguments started to seem ridiculous and indefensible even to her, but she had become locked into them as they were still consistent with her basic premises and as she had come this far with me it was impossible to do an about-turn without exposing the flaws in her original position. Her only way out was to start coming up with her own reasoning against where I had taken us. I had come to represent the worst and most extreme aspects of her own behaviour and in order to save face she had to take me, and what I was representing about her, on. Eventually she started to make some quite reasonable points to show she was not as stupid as my performance was making her appear. These included:

- "Sometimes my bedroom does get too grotty for me."
- "Sometimes mum deliberately leaves my clothes under the bed for too long and the room has got smelly, even friends have said something." She shifted on this point from initially blaming her mother for leaving the clothes there to saying "I guess it wouldn't take much for me to take them to the laundry."
- " I don't think we're that smart about sex."
- "The idea of having sex is exciting but it scares the shit out of me."

- "I'm not just gonna have sex with anyone."
- "You can't just decide to have a baby to get money off the government. What if everyone did that? The country'd go broke."

At this point I turned on her and asked her where all this sensible shit was coming from and "You're sounding just like your parents!" She began to defend herself and spontaneously came up with the insightful response "I'm not a total fuckwit even if I act like one. I know when I'm bullshitting to keep them off the track but I'm not going to be so stupid that I ruin my life completely!"

Her parents were by now realising what was happening and, as they confessed later, were beginning to enjoy the show being presented by their daughter and me. They had begun to understand what I was doing and participating in the spirit of that, for example pretending to be persuaded by some of my absurd arguments or feigning self-mockery. Some weeks later the mother reported that her daughter had implemented some changes at home and that they were beginning to talk about some of the issues that had been concerning the parents, especially around sex and drugs. She also advised that quite often when they started arguing about the issues burlesqued during the session they would see the ridiculous or funny side to it and this would take the sting out of the argument.

Instead of doing more of what had already been done and failed, which had been to take on the daughter's argument directly by opposing it, therapy went with her points but took them into a realm where their unreasonableness not only became obvious but also hilarious, with all four participants in the session laughing together about them. The humour was an essential vehicle for the daughter to see her argument as ridiculous and thereby be able to challenge it herself, and for the parents to be able to poke fun at the role they had been playing as well as laugh with their daughter about what they had previously always been in conflict about. Laughing together had replaced arguing against each other.

Milton Erickson is perhaps the best known psychotherapist to get clients to approach their problems and solutions indirectly. This approach is particularly indicated where direct attempts

to solve the problem have repeatedly failed as in the following case example of Erickson's, recorded by his friend and colleague Sydney Rosen in his book *My Voice Will Go with You: The Teaching Tales of Milton H. Erickson* (1982).

A woman came to see me and she said, "I weigh 180 pounds. I've dieted successfully under doctor's orders hundreds of times. And I want to weigh 130 pounds. Every time I get to 130 pounds I rush into the kitchen to celebrate my success. I put it back on, right away. Now I weigh 180. Can you use hypnosis to help me reduce to 130 pounds? I'm back to 180 for the hundredth time."

I told her, yes, I could help her reduce by hypnosis, but she wouldn't like what I did. She said she wanted to weigh 130 pounds and she didn't care what she did. I told her she'd find it rather painful. She said, "I'll do anything you say." I said, "All right, I want an absolute promise from you that you will follow my advice exactly."

She gave me the promise very readily and I put her into a trance. I explained to her again that she wouldn't like my method of reducing her weight and would she promise me, absolutely, that she would follow my advice? She gave me that promise.

Then I told her, "Let both your unconscious mind and your conscious mind listen. Here's the way you go about it. Your present weight is now 180 pounds. I want you to gain twenty pounds and when you weigh 200 pounds, on my scale, you may start reducing."

She literally begged me, on her knees, to be released from her promise. And every ounce she gained she became more and more insistent on being allowed to start reducing. She was markedly distressed when she weighed 190 pounds. When she was 190 she begged and implored to be released from her own promise. At 199 she said that was close enough to 200 pounds and I insisted on 200 pounds.

When she reached 200 pounds she was very happy that she could begin to reduce. And when she got to 130 she said, "I'm never going to gain again."

Her pattern had been to reduce and gain. I reversed the pattern and made her gain and reduce. And she was very happy with the final results and maintained that weight. She didn't want to, ever again, go through that horrible agony of gaining twenty pounds (pp. 123-124).

The reasonable thing for her to do was what she had always done, that is aim to get to 130 pounds by losing weight. It appears absurd to aim to get to 130 pounds by putting on twenty

pounds, especially when doing so causes her so much pain. On closer examination, however, it is absurd to repeatedly do something that always leads to the same undesirable outcome, that is to lose fifty pounds only to regain fifty pounds immediately. She had continued to use the same approach of directly addressing her weight problem for many years, which probably seemed a reasonable thing to her, even though it failed every time, which is absurd. Of course, this is how people usually approach problem-solving irrespective of how often their attempts fail. The reasonable approach to solving problems becomes absurd if it does not work. This relates to the adage: if you keep doing what you've been doing, you'll keep getting what you've been getting.

In a way, there was a sense of security about always returning to 180 pounds, but not more than 180 pounds. Rosen comments that 180 pounds had become tolerable even though undesirable.

> She apparently had learned to be able to tolerate gaining weight only up to 180 pounds. We see this in many weight patients. They have a level of tolerance, at which they urgently feel the need to reduce. Erickson succeeded in making this tolerance level intolerable because he made her go beyond it (p. 125).

Her 'safety net' had allowed her to continue in the same pattern of weight gain-loss-gain, however much she consciously wished to get out of it. Paradoxically, removing the safety net provided her with the motivation not to depend on it. It also gave her the experience of gaining weight without the security of knowing it will always stop at the same point. In this case the intervention, putting on weight in order to lose it and continuing to do something against a powerful desire to stop doing it, appears to be absurd but the rationale underlying it is reasonable.

Erickson was also well known for his creative use of metaphors, anecdotes and analogies – talking about problems and approaches to solving them without addressing them directly or sometimes even mentioning them specifically at all. The therapeutic use of metaphor is presented in the next chapter. I would like to close this chapter with a response made by Erickson, in the later years of his life, on hearing that one of his students was concerned that Erickson might soon die.

I think that is entirely premature. I have no intention of dying. In fact, that will be the last thing I do! My mother lived to be ninety-four; my grandmother and great-grandmother were all ninety-three or older. My father died at ninety-seven and a half. My father was planting fruit trees, wondering if he would live long enough to eat any of the fruit. And he was ninety-six or ninety-seven when he was planting fruit trees.

Psychotherapists have a wrong idea about sickness, handicaps, and death. They tend to overemphasize the matter of adjustment to illness, handicaps, and death. There is a lot of hogwash going around about assisting families in grieving. I think you ought to bear in mind that the day you are born is the day you start dying. And some are more efficient than others and don't waste a lot of time dying, and there are others that wait a long time.

My father had a massive coronary attack at eighty. He was unconscious when he was taken to the hospital. My sister went with him; the doctor told my sister, "Now, don't have too much hope. Your father is an old man. He worked hard all of his life and he's had a very, very severe coronary." And my sister said, "I snorted at the doctor and said, 'You don't know my dad!'" When my father recovered consciousness the doctor was there. My father said, "What happened?" The doctor told him, "Don't worry, Mr. Erickson, you've had a very bad coronary attack, but in two or three months you'll be home as good as new." My father, outraged, said, "Two or three months, my foot! What you mean is I've got to waste a whole week!" He was home in a week's time.

He was eighty-five when he had his second and similar heart attack. The same doctor was there. My father recovered consciousness and said, "What happened?" The doctor said, "Same thing." My father groaned and said, "Another week wasted."

He had a drastic abdominal operation and had nine feet of intestine removed. When he came out of anesthesia, in recovery, he asked the nurse, "Now what happened?" she told him and he groaned and said, "Instead of a whole week it'll be ten days."

His third heart attack occurred when he was eighty-nine. He recovered consciousness and said, "Same thing, doctor?" The doctor said, "Yes." My father said, "Now this is getting to be a bad habit of wasting a week at a time." He had his fourth coronary at ninety-three. When he recovered consciousness he said, "Honest, Doc, I thought the fourth would carry me off. Now I'm beginning to lose faith in the fifth."

At ninety-seven and a half he and two of my sisters were planning a weekend trip to the old farming community. All his peers were dead and some of their children. They planned whom to visit, what motel to stay in, what restaurants to eat at. Then they walked out to the car. When they reached the car my father said, "Oh, I forgot my hat." He ran back for his hat. My sisters waited a reasonable length of time and then looked at each other coolly and said, "This is it." They went in. Dad was dead on the floor of a massive cerebral hemorrhage.

My mother fell and broke her hip at ninety-three. She said, "This is a ridiculous thing for a woman my age to do. I'll get over it." And she did. When she fell and broke the other hip a year later, she said, "Getting over that first broken hip took a lot out of me. I don't think I'll get over this one, but nobody will ever say I didn't try." I knew, and the rest of the family knew, by my blank face, that the second broken hip would be her death. She died of congestive pneumonia, the "old woman's friend."

My mother's favorite quotation was "Into each life some rain must fall. Some days must be dark and dreary." Longfellow's "The Rainy Day." My father and my mother enjoyed life thoroughly, always. I try to impress upon patients: "Enjoy life and enjoy it thoroughly." And the more humor you can put into life, the better off you are. I don't know where that student got the idea I'm going to die. I'm going to put that off (Rosen, 1982, pp. 167-169).

CHAPTER 6: TECHNIQUES/STRATEGIES/INTERVENTIONS IN ABSURD THERAPY

ABSURDITY AS PARADOX AND HUMOUR

The discussion of absurdity in this thesis is mostly focused on humour and paradox, providing comprehensive descriptions and discussions of both. Of the two, paradox has been developed and used as a psychotherapy technique the most (Haley, 1963, 1973, 1976; Watzlawick et al., 1967, 1974; Frankl, 1967, 1975a, 1975b; Andolfi, 1974; Selvini Palazzoli et al., 1978; Madanes, 1981; Rohrbaugh et al., 1981; Weeks & L'Abate, 1982; Boscolo et al., 1987; Ascher, 1989).

Paradox and humour can appear in therapy sessions quite differently. Paradox is often introduced into the session quite seriously, sometimes even formally, as a thought through goal-oriented strategy whereas humour is more likely to arise, or at least appear to arise, spontaneously and as a natural part of the interaction between therapist and client. This difference leads to questions, to be discussed shortly, about the deliberate use of absurdity as a technique as opposed to it arising spontaneously in a therapy session.

Although many paradoxical interventions described in the professional literature are presented to clients in a serious manner, paradox can also be introduced into the therapy session in the company of humour (Frankl, 1967; Haley, 1973; Farrelly & Brandsma, 1974; Andolfi et al., 1989). This association is possibly becoming more common as the therapeutic use of humour becomes more common. Humour and paradox have strong similarities, especially in that both involve incongruity and trigger reactions of surprise and perplexity. In her review of the literature on the clinical use of humour, Buckman refers to the position taken by a number of clinician authors that:

> ……paradox is the paradigm for humor, with laughter occurring at the moment when a circuit of that kind is completed. They consider therapy a place where the freedom to admit paradox has been cultivated as a technique. The freedom to talk nonsense, to entertain illogical alternatives, and to ignore the theory of types is essential to any relationship, including the therapeutic relationship (1994, p. 15).

Buckman's point that laughter occurs "when a circuit …is completed" reflects the position of configurational or incongruity-resolution theories of humour that consider the humour response

as arising not from the incongruity itself but from suddenly seeing through or making sense of it. Alternatively, some incongruity views of humour hold that it is the incongruity itself, before or even regardless of it being resolved, that triggers the humour response.

> As maintained in incongruity theories, it is the perception of "disjointedness" that somehow amuses. In configurational theories, it is the "falling into place" or sudden "insight" that leads to amusement (Keith-Spiegel, 1972, p. 11).

The proposition that the humour response arises from an experience of incongruous notions or events, the basis for the various incongruity theories of humour, has gained the most support amongst philosophers and researchers of humour. As mentioned above there is some debate as to whether the humour response is triggered simply by the experience of incongruity, or requires cognitive resolution of the apparent incongruity as in Buckman's quote. There is also debate as to whether it is sufficient for the experience to be perceptual and cognitive or if there has always to be an emotional component for it to be humorous. Whichever it may be, and perhaps it can be both, the role of incongruity in humour, and absurdity generally, is seen as critical by most theorists and practitioners of humour.

Whatever it is that triggers the humour response, incongruity is undoubtedly the central element in paradox and in most humour, at least in its more sophisticated forms. Paradox arises from the co-existence or presentation of two apparently contradictory statements, notions or events. The demand to validate or respond equally to the contradictions usually produces a response of surprise, possibly confusion, perhaps chaos, and can trigger creative insights, as with some artistic and scientific breakthroughs and as is strived for by Zen practitioners as they contemplate koans such as "what is the sound of one hand clapping?". In a humorous context, the response brings with it laughter and, undoubtedly, at times also does so in the artist's studio, research laboratory or Zen monastery.

Through my research I have identified a large number of therapist behaviours, techniques or strategies that can be considered as examples of therapeutic absurdity. In my professional practice I have also developed numerous absurdity-based therapist activities of my own. As

with therapeutic style in the previous chapter, I have generated general categories into which these activities can be allocated. Though not as comprehensive as my list, there are, in the psychology literature, a few other attempts to categorise paradoxical techniques, such as Rohrbaugh et al. (1981), and therapeutic humour, such as Killinger (1977, 1987) and these are worth looking at before moving to my classification.

Paradox

Rohrbaugh et al. (1981) allocated paradoxical therapeutic interventions into two general types, compliance-based and defiance-based, and then further identified sub-types of each. Compliance-based interventions are ones that require clients to attempt to carry them out whereas defiance-based interventions are designed to provoke clients to resist or oppose them. Examples of the former are symptom prescription as discussed later in this chapter and Erickson's weight loss case described in the previous chapter. The following vignette provides examples of both compliance-based and defiance-based paradoxical strategies.

A married middle-aged couple sought help for regaining their sex life. They stated that they had not had sexual intercourse for over a year because the husband had been unable to gain an erection whenever they attempted to do so. He was, however, able to have erections and masturbate on his own. Sex had not been a problem for them previously and he stated that he still found his wife attractive and they still loved each other. He was able to recognise that he now became anxious and anticipated impotence whenever the possibility of having sex occurred. He expressed great concern that his problem was undermining his wife's confidence and self-image as well as his own. I pointed out to them that the mere threat of sex was an immediate trigger for his anxiety and impotence and told them that it was essential to remove this threat, in other words to agree not to have any sexual contact, for quite some time if he was to have any chance of overcoming his problem. After some discussion they, somewhat reluctantly but appreciating the rationale, agreed to have no sexual contact for the next three months. They were to continue sleeping in the same bed but not touch each other.

I then asked to speak with the husband privately to "have a man talk". I advised him that he should continue to masturbate during this time and if he was still unable to gain an erection with his wife at the end of the three months we should add a further three months of no sex. I suggested that he was in a win-win situation. If he really wanted to regain a sex-life with her, this was his only chance of achieving it. If, on the other hand, his unconscious mind was really trying to remove the threat of sex, after six months of a voluntary and mutually agreed prohibition on sex it was likely that his wife will have given up and lost the urge herself. We could then extend the period to a year after which time sexual desire would be a distant memory. He appeared to squirm a little at this point but agreed that our strategy did appear to leave open both potential outcomes.

I then explained to the husband that I had to meet with his wife on her own as she needed to be able to talk about her own feelings in private, which he understood as he was concerned about how his impotence was affecting her. She stated that she would do anything to help her husband regain his manhood. She was still a very sexually attractive woman but expressed the fear that she was beginning to lose her sensuality and ability to feel sexual. We agreed that it was important for her to keep these feelings alive in herself which allowed me to give them a rationale for what I asked her to do next. I recommended that on their way home they go to a lingerie shop together and that she purchase a range of sexy nightwear that she was to wear every night for the next three months. In our private discussion I also recommended that she "get in touch with your sexuality just before, while, and just after going to bed" and to let him see her being sexual but that neither of them were to touch the other. She liked this idea and even decided she was going to start reading sexual and pornographic literature before going to sleep. Her reaction was interesting because she had been telling herself she should not feel sexual or do sexually stimulating things to herself while he was unable to respond to her. My recommendation gave her permission to do so.

The recommendations to continue, or in the wife's case to resume, individual sensual and sexual behaviour were based on the assumption that each would agree to do so. The insistence that they have no sexual contact with each other was a defiance-based paradoxical strategy that arose from the assumption that the husband would eventually be unable to continue going

along with it. I have to confess, I was expecting it to be a few weeks before the husband would rebel, given his impotence had lasted for more than one year. Less than two weeks after this initial session they phoned requesting an urgent appointment. His moment of rebellion had been rather humorous as, his wife reported, throwing off the sheet and revealing a fully erect penis, he yelled out, "Look at this bloody thing, I can't go to sleep with this! I want sex! Fuck that psychologist! No, I mean fuck you … I want to fuck you!" Some months later they wrote to me advising that they were continuing having sex and thoroughly enjoying it.

Rohrbaugh et al. (1981) further classified paradoxical interventions into three sub-types: prescribing; restraining; positioning. Prescribing has already been referred to and was what I was doing in the previous vignette where it can be seen that it can be both compliance-based and defiance-based. Restraining can involve the therapist appearing to discourage clients from changing, advocating they slow down the pace of change, or predicting they will not change. These are essentially defiance-based paradoxical communications with the intent being for clients to disagree, rebel against or prove wrong. Rohrbaugh et al. (1981) sub-divided this category into two sub-types of 'soft' and 'hard' restraining as interventions related to how entrenched the problem is and how oppositional the client is.

> *Soft* restraining embodies the message: "You probably shouldn't change." For example, the therapist may tell the patient to "go slow" or worry with the patient about possible dangers of improvement. *Hard* restraining is defined by the message: "You probably *can't* change." The therapist mobilizes resistance by benevolently suggesting that change may not be feasible (p. 456, italics in original).

Soft restraining

Examples of soft restraining with a bulimic client could be:

- Perhaps you're not yet ready or willing to let go of your vomiting completely, after all it does provide you with a safety valve. You had better keep vomiting, say three times per week instead of your usual once per day, to satisfy the part of you who thinks you need to do this, or to prove you still can do it.
- Don't get rid of the bulimia totally (at least not yet) as it has served you well in the past (for example as a stress management technique, excuse to avoid social gatherings, or way to reassert to yourself how disgusting you are). The therapist might casually point out that if the client did not vomit she might discover some useful methods of stress management that actually work, might get a social life or might start thinking she was not that bad a person after all. "We couldn't have that could we?"
- The therapist has a bet with the client about whether or not they can change. A sixteen-year old bulimia sufferer I had been seeing for over a year had managed to remain binge-purge free for two months. Previously, at her worst, she had been bingeing and purging at least once every day. She was expressing confidence about finally being in control of her bulimia but she had a history of short-term successes collapsing into relapses twice as bad as her previous state. I was fairly confident that she could resist bulimic temptation but felt she needed an added incentive. I bet her my fee that she would not survive the next four months without being taken over by the 'bulimia bitch' (my depiction of the part of her that cons her into bulimic behaviour). I appointed her mother as the judge. My client rose to the occasion. I am certain that proving me wrong was a greater incentive than the money. Four months later she sat in my office with her mother, grinning from ear to ear, hand outstretched to receive her winnings. I asked her mother to pay me that day's fee, which she did in cash, and immediately passed her money on to the daughter who beamed at both of us relishing her victory. I bumped into this ex-client a couple of years later and had a coffee with her in a café nearby my rooms. She described how she had been determined to stay free of the bulimia, and win that bet, even though it still felt abnormal to do so. She explained that resisting the bulimia remained a struggle for some time after ceasing therapy, and that she had to remain determined to do so, but that at some point it seemed to become normal not to be bulimic and the thought of bingeing or purging became abnormal.

Hard restraining

Therapists working with paradoxical techniques would be more likely to use hard restraining with entrenched, chronic problems and with more oppositional, resistant clients. Underlying these approaches is faith that the person can change irrespective of chronicity or oppositionality. The implication is that people want to change difficult circumstances but might hold fears (perhaps not conscious) of doing so or have little sense of the possibility of them doing so. Often the problem behaviour has become well established as a long-standing habitual pattern with social contexts organised around and supporting it.

At our first meeting a female client in her early thirties described her five-year de-facto relationship with a man who physically and emotionally abused her and was verbally aggressive towards her two young children from a previous relationship. He did not work, spent most days at home drinking alcohol, and, according to her, "never lifted a finger around the house". She did all of the housework and had two jobs – one full-time and one part-time evening work. She came to see me because she was feeling depressed, not good enough as a mother and partner, and generally suffering with poor self esteem. She explained that she had seen a few counsellors and social workers but had found none of them to be helpful. The fact that she had already sought a lot of help suggested to me that she did want to solve her problem but was entrenched in the relationship and fearful to be out of a relationship.

I presented a number of themes to her during our first session (these were the words I used):

- God knows why, but it appears you *need* to be with this guy.
- In this world there are strong people and there are lily-livered, yellow-bellied, cowardly, weak people. The beaters and the beaten. I guess it must be in their nature or something. Whatever, they do seem to depend on one another.
- You must really be a resilient person to have survived five years of this. You do seem to be a strong person underneath it all. Good loving mother too – though plenty to protect them from. This guy does seem to bring out the best in you. Maybe this is your calling, your fate, your duty.

- So it is great (for him) that you are applying all your strength and resilience to his welfare and to bolster his sense of self-worth. Let's face it, every parasite needs a host – ideally one who'll stick around. Parasites are dependent you know. They need a reliable host.
- Have you thought of getting a third job?

She was not happy when she left my office. We had an appointment booked for a week later and I was relieved when she turned up for it. She described having felt very angry with me as she walked along the street from my office, but as my words sank in she became angry with him, and by the time she arrived home she was angry with herself and, specifically, how she was staying in the "blaming victim role" at the expense of herself and her children.

Positioning

Paradoxical positioning involves therapists appearing to agree with clients' problematic 'positions', such as negative self-statements or problematic behaviours, but then taking their position further, for example by exaggerating it. Farrelly's description of Bill's 91st interview, quoted in the previous chapter, is an excellent example of this. Rohrbaugh et al. (1981) believe this intervention to be most useful:

> … when the person's position is assessed to be maintained by a complementary or opposite response by others. For example, when a patient's pessimism is reinforced or maintained by an optimistic or encouraging response from significant others, the therapist may "outdo" the patient's pessimism by defining the situation as even more dismal than the patient had originally held it to be (p. 456).

Constructivist positions depict a person's reality as emerging primarily from their own mental and social constructions. This does not necessarily imply that no objective reality exists beyond human experience, though some philosophers do argue this case, but that the realities we operate from are our representations of whatever might 'really' be happening. Facts, according to this view, are only subjective 'facts', representations, reinforced through social interaction and shared belief.

Paradoxical therapeutic positioning is based on the assumption that however 'factual' a person might believe their self-statements are, they can be transformed into different representations. Self-statements become 'facts' through repetition and have often arisen from repeated statements (including nonverbal) by significant others in the person's life. In other words, certain things people come to believe about themselves can grow out of representations significant others have made of them, that eventually become entrenched as part of the person's self-representation and manifested through their behaviour which in turn reinforces the representations being made about that person by others. This is a feedback loop of others' representations → the person's self-representation → behaviour reflecting that self-representation → others' experience of the person reinforcing their representation of that person.

This is not to say that all aspects of a person's self-image emerge from communications with significant others, as life involves continuous exposure to an enormous variety of experiences, many of which can leave a person with profound impressions. Nevertheless, there is general agreement amongst psychologists that beliefs about self are significantly influenced, some would say largely determined, by others' representations and communications about that self, especially in the early years of a person's life and especially where the others play a significant role in that person's life.

As a person comes to believe something about their self, they behave in ways that reflect or represent that belief and other people respond to those behaviours. As this process is repeated and perpetuated the person's self-belief is reinforced, confirmed to be 'fact', by others' responses. These can become powerful collusions, habitually and unconsciously maintained as facts by all concerned and thereby likely to be resistant to attempts to change them. Direct attempts to change these self-beliefs, such as through reasoned discussion aimed at pointing them out, are often fruitless due to them being entrenched and interpersonally reinforced. However problematic for the person or others they might be, these self-beliefs and behavioural patterns can become predictable, familiar and, in a sense, even comfortable. Obvious attempts to challenge them can therefore be threatening to the person's, or their significant others', need for predictability, familiarity and comfort. This can be especially problematic for therapists working with co-dependant relationships.

I recall the first assertiveness training group I was involved in running. All but one of the group members were housewives and mothers with children or adolescents living at home. The group met for two hours weekly and was scheduled to last for eight weeks. By the fourth week, participants had learned various assertiveness skills and were asked to practice them with their families. By week six, it was obvious to everyone that simply going home and "asserting all over the family", as one group member put it, was not going to work. Group members described various reactions from their husbands and children to their newly found assertive behaviour, including disbelief, anger and the whole family bursting into laughter. Family comments included things like "you've got to be kidding", "sure mum, now will you just do it for me", "now you've got that off your chest, can you get me the ….?", "I want you to stop going to that group, it's making you act weird". Group members would immediately feel hopeless about changing and revert to previous unassertive behaviours. It was decided to extend the schedule to ten weeks and that the co-therapists would directly address this problem during sessions in weeks seven and eight. We did this by role-playing group members' assertive and unassertive behaviours and family members reactions. This was a fairly standard thing to do in groups such as this but how we went about it was not. The role-playing started with reported behaviours but steadily took these into the realm of the ridiculous. These two sessions were like pantomimes with the therapists and, after some initial hesitation, group members building their families and their own actual behaviours and comments into hilarious caricatures. Group members went home feeling they could withstand any reactions to their, now even livelier, attempts to be assertive, especially as they could see the funny side not only to their families' behaviours but to their own.

Paradoxical positioning techniques are meant to take clients' 'facts' or beliefs about themselves beyond the familiar to a point at which they will become uncomfortable and no longer 'ring as true'. Perhaps at some level this group of paradoxical techniques reveal the manufactured nature of 'facts' people hold about themselves and others.

Humour

In describing her behavioural research studies of clients' responses to humorous interventions by therapists, Killinger (1977, 1987) developed a categorisation of the interventions therapists were observed to be performing that has a number of similarities to the one I have developed. Killinger's categories were developed through observations of therapy sessions in which therapists made humorous statements to which clients responded with laughter. The therapists' laughter-inducing statements were subsequently placed into the following seven categories.

Exaggeration or simplification with which therapists either overstate or understate aspects of clients' problems, such as through "dramatization, imitation, mock seriousness, nonsense, absurdity, slapstick".

Incongruity, including through the use of irony, satire and paradox and with the intent of producing a comic effect.

Unexpectedness or surprise, such as through play on words, expressing incredulous disbelief, dramatisation, paradox. Killinger presents linguistic examples of how therapists can surprise and perplex clients but there are also many nonverbal means to do this, a number of which are described later in this chapter.

Revelation of truth, for example through self-disclosure that could be dramatised or used as a metaphor for clients' situations. Discussion and examples of therapist self-disclosure as metaphor can be found later in this chapter.

Superiority or ridicule which can include teasing, bantering, mimicry, satire, or derision. Most commentators on the use of humour in therapy consider many of these forms of humour to be inappropriate in therapy. In presenting this category of interventions, Killinger states:

> The use of the superiority or ridicule technique in particular is often a risk-taking venture. Although the effective therapist does take risks in an effort to urge clients to stretch and grow, one cautionary note is in order. Sarcasm and vindictive ridicule or mimicry that fall within the superiority technique have no place in psychotherapy (1987, p. 34).

This view is echoed by Buckman in her preface to *The Handbook of Humor* (1994):

> There are five types of humor that are totally inappropriate for the therapeutic setting: ridicule, laughing at the client, cheap shots, put-downs, and sarcasm. These convey veiled anger and hostility for the client and can only be considered unethical. Insofar as humor expresses anger, discontent, conflict, and sadness, albeit through a healthy, enjoyable, and interpretive mode, the therapist must remain ever vigilant about the power of this type of intervention, and sensitive to the client's needs, emotions, and status of the therapeutic status and relationship (p. xvi).

Repression or release of both tension and pleasure, especially associated with taboo topics, such as sexuality and fear, and being able to laugh at oneself. This was referred to by Andolfi et al (1989, p. 87) as the "sudden burst of tension" that "induces everybody to ask themselves new questions". Their full quote can be found in the surprise-techniques section of this chapter. This category relates to the release theories of humour, which include Freud, as described in chapter 3.

Word play such as nonsensical logic, comic verse, play on words, punning, farce, turning issues into comedy. My classification places different types of word play into categories of playfulness and joking, provocation such as through satire, and indirect interventions such as humorous songs and poems.

Killinger also noted that a humorous intervention can fall into more than one of these categories. In her study, interventions were identified on the basis that they had triggered a laughter response in the client. That is, when a client laughed in response to something the therapist said, whatever the therapist had said was deemed to have been a humorous intervention. On subsequently replaying the audiotapes of sessions she also identified therapist statements that could be seen as humorous but were not followed by an audible laughter. These statements tended to be more subtle and clever, such as "a figure of speech, or some clever, unusual, or original phrasing of words that allowed one to play with the ideas or thoughts presented" (p. 25), and probably triggered more subtle nonverbal humour responses in clients not able to be

recorded on audiotaps. To account for these interventions, she added a "**nonlaughter**" category into which interventions from any of the other seven categories could be placed.

Before moving on to my own categorisation of therapeutic absurdity techniques some further comments regarding the issue of using "superiority or ridicule" are worth making. Killinger made the point that "sarcasm and vindictive ridicule" are inappropriate in therapy and it would be difficult to argue that therapists can ever justify being vindictive towards their clients (though, unfortunately, this certainly does occur). Can ridicule, mockery, and poking fun at the client ever be justified as therapist behaviours towards clients? Farrelly thinks they can.

> Ridicule is the form of humor which raises the most professional eyebrows and questions, and perhaps rightly so, for if not qualified, it can be hurtful. In defense of this technique, however, we would like to point out its potency…. We think that the enterprise of psychotherapy must explore all available techniques to become a powerful, effective agent for change. We want the client to vigorously and insistently protest against his own self-destructive attitudes which have been externalised by the therapist. He provokes the client with content or mock pomposity to "put him down" and be assertive with him (Farrelly & Brandsma, 1974, pp. 102-103).

Presumably "not qualified" implies that ridicule must be appropriate to the context, not just of any type or severity, or vindictive, or that it must be modified or countered by the therapist's nonverbal communications. It may even refer to both of these ways to qualify what the therapist is saying verbally when ridiculing the client. Farrelly certainly emphasises the importance of nonverbal behaviour in provocative therapy. For example in defending the use of sarcasm, another potentially potent and risky technique, in therapy, he says:

> The dictionary talks of sarcasm with words like cutting, hostile, contemptuous, caustic, and ironic. Although these adjectives could at times be applied to the provocative therapist's verbalizations, his "sarcasm" is almost invariably qualified by his facial expression, tone of voice, etc (Farrelly & Brandsma, 1974, p. 109).

Perhaps "should always" would be more reassuring than "almost invariably". What degree of communication skill and self-awareness does it require to be able effectively to qualify nonverbally the considerable potential destructiveness of sarcasm and ridicule, especially when these are being directed to people already vulnerable and suffering as many seeking therapy

are? How does the therapist, supervisor or trainer monitor how well the ridicule or sarcasm is being qualified? On the other hand, perhaps the ability to qualify ridicule and sarcasm does come naturally to most people. After all, it is a commonly found occurring between good friends. Friends can spend a lot of time playfully teasing each other but this can also involve statements that in a different context would be seen as insulting. Calling a good friend a "fat bastard" or "dumbfuck" is unlikely to lead to conflict, particularly as it would normally be said with the kinds of nonverbal qualifiers Farrelly is referring to.

The important variable here is the therapist's attitude towards the client. It is unlikely that a therapist would be able to qualify ridicule or sarcasm towards clients successfully unless feeling respect for them and being able to empathise with them, in a similar way that one normally would with a good friend. This leads to another defence of ridicule as therapeutic intervention that has been offered, which is that it should separate the problem from the person, in other words ridiculing things the person does, says, thinks, believes or feels while maintaining empathy or respect for "the person him or herself".

> Another distinction to clarify the use of ridicule in provocative therapy is that the therapist's ridicule is directed at the client's crazy ideas and self-defeating behaviours, while his non-verbal warmth and caring are directed at the person of the client. While persons should not be ridiculed, our stance is that ridiculous ideas and behaviours merit ridicule (Farrelly & Brandsma, 1974, p. 107).

As with the previous criterion, this is not necessarily a straightforward thing to do and it is difficult to gauge how well a therapist may be achieving it with each intervention. It is obviously usually a very subjective decision to make about another person and it may be a somewhat artificial distinction anyhow. To what extent can people be separated from what they are saying, thinking, feeling or doing at any one time? This involves a philosophical discussion beyond the scope of this thesis. Suffice it to say, the risk is that it provides a tenuous principle by which to ascertain whether or not certain types of intervention are acceptable.

A second point arising from this discussion relates to hypothesis #2 as stated in Chapter 1, that reason is a method of manipulation based on power and inequity whereas absurdity can be the

antithesis of this and a means to liberation and the unravelling of power. This is not to say that techniques falling under the absurdity banner are always based on equality. Some therapists well known for their use of humour, such as Farrelly, Albert Ellis, and Carl Whitaker's early style, maintain the impression of being one step ahead of the client, whereas others, for example Walter O'Connell, see humour and spontaneity as natural outflows only of an egalitarian relationship between therapist and client. Different forms of absurdity have different implications for power, for example ridicule and sarcasm can obviously be used as potent means by which to establish superiority and power.

THERAPEUTIC ABSURDITY 'TECHNIQUES'

The previous chapter's categorisation was to do with therapists' style and the ambience thereby created in therapy sessions whereas the following groups different types or categories of specific techniques, interventions or behaviours performed by therapists towards clients that could be considered absurd. I have developed categories of style and interventions that, to some extent, correlate to make cross-referencing between the two possible.

As with the previous chapter's categorisation of therapist style, therapist interventions have been grouped into six categories. Each of these categories includes a comprehensive presentation of techniques falling within its realm.

The categories are:

- Techniques involving the unexpected and eliciting a reaction of surprise.
- Interventions meant to 'turn up the heat' and create tension that may or may not be released in the session.
- Therapists being playful, comical, playing the clown.
- Therapists provoking and parodying clients.
- Paradoxical interventions.
- Indirect and implicit approaches.

I will discuss each of these in detail but first some general comments are in order.

There is an inter-relatedness between style and ambience and therapists' actual behaviours, strategies or techniques with each influencing or arising from the other. For example a therapist's personal and professional style, beliefs and attitudes will often influence her preference for and selection of therapeutic techniques. As she gives preference to particular techniques and approaches to doing therapy, in turn her overall style and ways of relating to clients can become modified. The therapists' behaviour in sessions reflects a combination of her style, her attitudes towards the client and the specific things (behaviours, techniques, strategies, interventions) she is doing.

Absurd interventions can be introduced into a therapy session in different ways, such as seriously or humorously and with or without a rationale being given to the client for what the therapist is doing. In some cases therapists can be quite formal, perhaps even adopting a superior position with clients, and can be operating totally from a cognitive and rational position, while introducing a paradoxical strategy, such as prescribing the symptom. In these cases, therapists would normally present to clients a rationale for the intervention, giving them a reasonable framework to understand the point of the strategy and why they should adopt it. Absurd therapeutic interventions can also be introduced in the serious mode but without providing a rationale, or providing the client with a false rationale, such as the reason given to 'Steven' why he was to continue with his strange behaviour described in the previous chapter on therapy style in the section 'unpredictability and novelty in the session'.

The same intervention can be presented humorously, with or without attaching a rationale, as occurs with the intervention known as paradoxical intention, developed by Victor Frankl (1967, 1975). Paradoxical intention involves a therapist instructing the client to practice intentionally unpleasant symptoms that normally occur involuntarily, such as panic attacks, phobic behaviours, compulsive behaviours, and obsessional thinking. The more cautious therapists who, nonetheless, are prepared to use paradoxical intention as a technique would probably introduce it to clients in the serious mode and carefully explain to them how and why it will work. For example, in his description of a paradoxical intention session with a female agoraphobic client, Ascher states that he first provided the client with a "protracted explanation

of paradoxical intention" and as her anxiety diminishes during the session he says to her: "Good. You see, this is the first experience you have had with the procedure in an actual anxiety-provoking situation, and you did very well with it. It is all a matter of understanding the procedure with respect to your concerns, and I think you are developing an understanding. Practice it as often as possible in fear-provoking situations" (1989, p. 119).

It can, however, work just as well as a humorous intervention without any rationale. One of my uses of paradoxical intention is to provocatively challenge clients to show me how well they can bring on a panic attack in my office. I do precede this in the serious mode by explaining to them the physiology of hyperventilation and its relation to panic attacks and then showing them how to slow down their breathing. My only condition in my challenge to them to have a panic attack is that they do not hyperventilate. As they inevitably find themselves unable to bring on an attack intentionally I become increasingly provocative and humorous, egging them on with taunts such as: "What's the matter with you? You told me this bloody thing can hit you at any time, any place, and yet you're not even able to get started." "Come on, let me have it! Give me the biggest, most terrifying panic attack you've ever had." "If this is the best you can do, you're just an amateur agoraphobic." Often I will excuse myself from the room saying that its becoming boring and I need a cup of tea and a biscuit. "You keep trying and I'll be back in five minutes to watch your spaz attack. If you somehow manage to get going before then, just scream." After their initial frustration and then embarrassment with their apparent inability to have the experience that until now they believed could hit them at any time, clients always burst into laughter, many of them expressing dismay, and sometimes relief, over the absurdity of what they are doing and experiencing as well as my lampooning, such as "So this is what you've been living in terror from for so long. They call it delusional you know."

Paradoxical intention does appear to be effective in the treatment of anxiety, phobias and obsessive compulsive symptoms, both in clinical settings and research studies (Weeks & L'Abate, 1982). This may be equally so irrespective of whether the intervention is presented in the serious mode or the humorous mode. I am unaware of any research into this variable and research into therapeutic efficacy tends to require the provision of a rationale to the subjects anyway thereby establishing the serious mode from the outset. At least if the different

approaches are equally useful an argument could be made in favour of the humorous in that it is obviously more engaging and animating, and probably more memorable, than the serious. Frankl also advocated that paradoxical intention should be "carried out in as humorous a setting as possible" (1967, p. 146).

With regards to absurdity in therapy generally, are there different types of therapeutic absurdity or different ways therapist can be absurd in therapy? What is the difference between absurdity as a therapeutic technique, strategy or intervention on the one hand and as a way of simply being with this person referred to as 'the client'? Absurdity can appear as technique, strategy or intervention with an intended effect or goal or it may simply arise as behaviours with no intended effect or goal in the therapist's mind, in other words therapists simply being absurd in the company of their clients who, in turn, just make of it what they will – unpredictable as that may be, or at least unpredicted by therapist or client.

These differences point to some questions alluded to early in this chapter. Can absurdity presented as deliberate strategy or technique, especially where it includes an intended or hoped for outcome as a consequence or response to it, really be considered to be absurd, or is it reason masquerading as absurdity? Though the therapist's behaviour or intervention may seem absurd to the client it arose from rational thought and a process of reasoning linking the therapist's behaviour (cause) to intended response (effect). Similarly, can the deliberate introduction of absurdity into a therapy session, done so with the intention to bring about particular responses from the client, be defined as absurd? In other words, can absurd therapy be goal-oriented with an intention to directly influence change in clients or can it only be a stimulation for the creation of an atmosphere of subversion and liberation from a dominant view or behavioural pattern?

The manner and intent with which therapists introduce ideas, activities, interventions, strategies, techniques to clients has implications for the therapist-client relationship, particularly in respect to power dynamics in that relationship, once an activity by the therapist is conceived as a technique or strategy intended to bring about change in the client. This is only a dilemma for therapists wanting to be absurd (though the issue of power and influence should be a dilemma considered by all therapists irrespective of how they work). Techniques based on

reason will, by definition, involve a power inequity between therapist and client. The question for therapists wanting to be absurd is whether or not conceiving of what they are doing as absurd techniques or strategies, possibly with intended or hoped for consequences, renders them no longer absurd.

There are also implications for the nature of change occurring for the client during or as a consequence of therapy. Reason becomes a means of persuasion to accept a dominant, widely-subscribed to position, one considered to be normal and sane. On that basis, reason-based approaches to change should therefore aim to persuade (assist) people (clients) to change to more conforming positions (such as beliefs, attitudes, behaviours). Perhaps the attitude to change holds the key to addressing the questions posed above. Psychotherapy, of whatever type, is about change of some sort. It is not that absurd therapists should have the attitude that change, as such, is not, or should not really be, the point of therapy or the motivation behind therapists doing the things they do with clients. It is how people view change, and the meanings they place onto psychotherapy, that can differentiate between reason and absurdity as approaches to change. If reason is a means to persuade people to adopt more reasonable, 'common-sense', positions, absurdity may be a means to create an atmosphere through which people can break out of old positions but discover, or stumble upon, new positions not influenced or predetermined by others or sociocultural norms and expectations. This can be the difference between change as adjustment to normality and dominant 'reality' or change as subversive, creating alternative 'realities', perhaps even transcendence beyond the need for 'realities'.

A further implication of this is that personal change is likely to be far more profound, and perhaps change can only be profound, if originating from the person herself rather than imposed or determined by other people, including therapists. This is the contrast between reaching within to one's own wellspring of possibilities, or arriving spontaneously at creative possibilities, as opposed to simply learning something new from another source or following someone else's suggestions. Even where the latter may be an improvement on whatever the person was doing or thinking previously, it is unlikely to be profoundly different but just another society-driven way of behaving or, even more superficially, an attempt, perhaps

unconsciously, by the 'changee' (client) to please or look good to the 'changer' (therapist). This is a characteristic of what is referred to in psychological research as the 'social desirability bias' in which people try to project a favourable impression about themselves to others and thereby describe themselves and behave in ways likely to elicit social approval.

The rest of this chapter comprises a comprehensive list and descriptions of therapist activities, interventions and techniques that are potentially absurd, although they may not always be so in how they are used by therapists. As mentioned earlier, I have placed them into six general categories correlating to some degree with the six categories of therapist style presented in the previous chapter.

SURPRISE/UNEXPECTEDNESS - techniques involving the unexpected and eliciting a reaction of surprise.

This category relates to ideas or events that bring about a sudden interruption to habitual cognitive, behavioural or interpersonal patterns. The element of surprise or the unexpected has been put forward by a number of theorists as a necessary component of a stimulus for it to trigger the humour response (Keith-Spiegel, 1972; Koestler, 1974; Fry & Salameh, 1987). Though this is often presented as a category in its own right, many of the techniques of therapeutic absurdity found in the other categories can include the element of surprise but will be discussed there. Many, but not all, absurd techniques involve or depend upon surprise or unexpectedness to be effective.

I can identify at least three possible ways surprise might contribute to new learning, insights or release from old behaviour patterns, particularly in a therapy session.

- The temporary space (cognitive, emotional) immediately following the surprise provides a window of opportunity for the introduction (usually by the therapist) of new material. This was what I did in *The Case of the Son Who Was Twisted in the Head*, when after having him in fits of laughter over my bizarre mimicking of his twisted head, I verbally confronted him with a strongly worded statement suggesting psychological reasons for his problem. Exponents of NLP (neurolinguistic programming) believe significant statements such as this

made by the therapist, when delivered at important moments, can be 'anchored' (their term) in the client's consciousness (or, NLPers might say, unconscious mind) by associated indicators that the statement is important, such as a momentary touch to the client's arm.

- The surprise jumbles the current lines of thought from which they fall into a creative rearrangement. The cases of Harold Greenwald and myself, described in the following section on creating tension, in which we surprise the clients with behaviour unexpected from therapists, such as sighing deeply, slouching in the chair, and making statements such as "you're only going to die anyway", can be seen as examples of this, as in each case the therapist's abnormal behaviour triggered new lines of thinking in the clients.
- In the aftershock from the surprising experience, the disoriented mind either: (i) urgently seeks meaning or sense (to rationalise the experience), or (ii) is able to appreciate, or at least tolerate, the anomalies or irrationalities of the experience, or (iii) either instead of or as well as one of the other two reactions, there is a release of tension (often explosively such as in laughter, crying, screaming or as an outburst of anger) emphasising that something unusual is occurring. Maurizio Andolfi and colleagues from the so-called 'Rome School' of family therapy refer to the relief produced by laughter when working with families.

> Laughter in therapy represents a kind of *sudden burst* of tension: a moment of apparent relaxation of the whole therapeutic system "taking a break". In reality the interruption has the purpose of shifting stress from the interpersonal space, or the area of relationships, to the more undefended and vulnerable internal space of each individual.
>
> It is precisely the suspension of action that follows laughter and produces a void, a very productive moment of silence, which allows reflection and induces everybody to ask themselves new questions. The direction of this cognitive self-inquiry will later be visible in someone's behaviour and will be confirmed in the overall emotional atmosphere. Not infrequently, therefore, after roaring with laughter one of the family members, apparently without motive, will break into tears or leave the session or else shoot a desperate look towards another family member or towards the therapist. In other cases laughter produces the opposite effect. From a feeling of boredom and helplessness in the family, laughter can reintroduce a feeling of hope, an emotional shock that reawakens vital energies (Andolfi, Angelo & de Nichilo, 1989, pp.87-88).

Here are two examples of surprise used by two well-known therapists and authors.

Some years ago Marcella de Nichilo, co-author of *The Myth of Atlas: Families and the Therapeutic Story* (1989), from which the previous quote was taken, related to me a case vignette involving the unexpected use of an unusual prop during a family therapy session at the Family Therapy Institute of Rome.

She was seeing a family in which she observed the father/husband persistently interrupting, talking over, and contradicting the other family members. Although he was not an aggressive man and he cared for his family, his behaviour was, symbolically at least, a forceful exercise of power which would stop the others in their tracks. The therapist, de Nichilo, was a short, middle-aged, maternal-looking, kindly woman. Behind her chair she had a large box filled with a variety of toys and props. At some point in the therapy session, after the man had 'punched out' each of the other family members on a number of occasions, de Nichilo reached back into the box, pushed her hand into a large foam fist, leapt out of her chair and 'punched' the man in the face. This was not as risky as it sounds. He was not an aggressive man, she was not a physically threatening woman, they had established good rapport, the foam fist would not hurt however forcefully it was brandished, and de Nichilo wore a cheeky expression on her face. After her leap of faith, de Nichilo plopped back into her chair and resumed the interview without directly referring to the incident. The implication in this kind of intervention is that the therapist has faith in clients' ability to process and get something from the intervention, either at the time or subsequently, and to understand the spirit in which it was done, though this will also depend on how the therapist performs the act, the context in which it occurs, and personality and interpersonal characteristics of the people involved.

The following intervention by Farrelly was initially surprising to the client but drew out an apparently uncharacteristic assertiveness from her to deal with the therapist's unexpected and frustrating behaviour. The therapist's behaviour would have been all the more surprising to the client as it was the first time they had met.

For example, a middle-aged, female patient knocked inaudibly on my door: when I went to answer it, she stood there humped over and almost hunched in upon herself.

Patient (*Querulously*.): "May I see you, Mr. Farrelly?"
Therapist (*Loudly*.): "Of course, Gorgeous." (*He strides back to his desk and sits down*..)
Pt. (*Coming into the room timorously*.): "Where do you want me to sit?"
T. (*Pointing at chair next to his desk; the patient begins to sit down in the chair*.): "Sit right there."
T. (*In a gruff tone; loudly*.): Hold it! No, (*pointing to a chair at the opposite wall*): "Sit over there."
Pt. (*Shuffles over to the chair at which the therapist is pointing*.)
T. (*In a commanding tone; looks around the office*.): "No, wait a minute…" (*He pauses, looks uncertain*.): I've got it! Sit over there (*pointing to a chair near the door*)."
Pt. (*Suddenly straightening up, frowning; loudly and forcibly*.): "Aw, go to hell! I'll sit where I want!" (*She plumps herself in a chair*.)
T. (*Throwing up his arms as though defending himself; plaintively*.): "Okay, okay, you don't have to get violent!"
Pt. (*Bursts out laughing*) (Farrelly & Brandsma, 1974, p. 181).

The element of surprise, the unexpected, can be a powerful intervention in human interactions outside the therapy room too, as demonstrated in the following example I received by email from a colleague. I am assured this is a true story but we can be sure of little in these days of cyber-folklore.

An award should go to the United Airlines gate agent in Denver for being smart and funny, and making her point, when confronted with a passenger who probably deserved to fly as cargo. During the final days at Denver's old Stapleton airport, a crowded United flight was cancelled. A single agent was rebooking a long line of inconvenienced travellers. Suddenly an angry passenger pushed his way to the desk. He slapped his ticket down on the counter and said, "I HAVE to be on this flight and it has to be FIRST CLASS." The agent replied, "I'm sorry sir, I'll be happy to try to help you, but I've got to help these folks first. I'm sure we'll be able to work something out." The passenger was unimpressed. He asked loudly, so that the passengers behind him could hear, "Do you have any idea who I am?" Without hesitating, the gate agent smiled and grabbed her public address microphone. "May I have your attention please?" she began, her voice bellowing throughout the terminal. We have a passenger here at gate 4 WHO DOES NOT KNOW WHO HE IS. If anyone can help him find his identity, please come to gate 4." With the folks in line behind him laughing hysterically, the man glared at the United agent, gritted his teeth and swore " Fuck you!" Without flinching, she smiled and said, "I'm sorry, sir, but you'll have to stand in line for that too." The man retreated as the people in the terminal applauded loudly.

This encounter differs from a therapy session in that the passenger is made an object of amusement in front of an audience whereas in therapy there is no audience or, in group therapy, the participants are actively involved and equal in status, not anonymous observers. The former

may be more explicable through superiority theories of humour whereas therapy tends to promote empathy and identity with the other. The presence of an audience can introduce extra elements of superiority ("at least I wasn't that stupid") and relief ("I'm glad that didn't happen to me") and perhaps also social cohesion amongst members of the audience at the expense and separation of the person who is the butt of the joke. These aspects of the humour response are discussed in Chapter 2 under theories of humour. Certainly an interaction between two people does not require an audience to be perceived as humorous. Individual therapy sessions do produce a humour response, as demonstrated in the numerous case vignettes in this thesis. This is also the case in bantering between two friends or where one or both do something they see as laughable, with laughter then occurring without the presence of an audience.

CREATING TENSION – interventions meant to 'turn up the heat' and create tension that may or may not be released in the session.

This category can be related to release-relief theories of humour. There are times when therapists introduce elements into therapy sessions that intensify clients' tension, frustration or even anger about a problem or aspect of their own behaviour and this can be based on either reason or absurdity. It takes some courage for a therapist to do this. By increasing clients' tension over their problems, therapists must be prepared to confront difficult issues and work with intense, at times unexpected, emotional reactions (certainly of the client and perhaps also of their own). Therapists may have to go to "where angels fear to tread" and sit with the tension created as long as felt necessary, not become the client's rescuer by prematurely defusing or deflecting from the tension.

When absurdity creates tension in a psychotherapy session it often initially triggers strong reactions, for example of bemusement, disbelief, grimacing and pleading with the therapist to stop, followed by tension-releasing behaviours such as laughter and yelling out (for example "aaaagh, stop it I don't want to hear anymore!"). This can produce relief both through an emotional discharge such as laughter or through a cognitive breakthrough as old thinking is

short-circuited and 'the pieces suddenly come together', as described in the previous section on surprise in the Andolfi, Angelo & de Nichilo quote (1989, pp.87-88).

Absurdity does have a tendency to arouse emotional responses in people. Paradox will often bring about surprise, confusion, amazement, disbelief and perhaps a gasp of realisation. There is some debate amongst humour researchers as to how much the initial perception of humour contains an emotional component but there can be no denying that the humour response, including laughter, can become primarily emotional. Humour and the off-balancing effect of paradox are not in themselves emotional states or reactions but they tend to bring about, at times profound, emotional, as well as cognitive, responses from people. Some therapies based on absurdity may be explicitly trying to intensify the emotional responses of the client such as in this description of Frank Farrelly's approach by Jaap Hollander on his internet homepage.

> Emotional involvement is paramount in provocative therapy. Simply try to get as strong an emotional reaction as you can (anything short of the client getting up and leaving)…This is one of the reasons why Frank talks about sex so much. By placing the themes the client comes up with 'in the bedroom', you are pretty sure to get a strong emotional response (Jaap Hollander homepage, 26/11/2000).

The following is a selection of apparently irrational examples of ways the therapist can 'turn up the heat' in the client and in the therapy session. They appear, to the client at least, to be irrational because they stand in contrast to reasonable expectations that therapy is supposed to help the client reduce, eliminate or at least defocus from their problems.

Creating tension 1: therapist exaggerating or outdoing the client's explanations and rationalisations.

This can involve overstating clients' presenting problems, speculating wild outcomes resulting from them continuing to have their problem, taking their current behaviour to its extremes, developing their problem to worst possible scenarios. Presumably, to be potentially therapeutic, these interventions rely on a hint from the therapist that they are not really serious, but lampooning the client's own rationalisations.

This is what Farrelly was doing in Bill's 91st interview described in the previous chapter. Perhaps a little surprised by his sudden self-affirmations that he might not be as bad or as hopeless as he had previously and consistently been presenting to Farrelly for ninety sessions, 'Bill' attempts to qualify these unfamiliarly positive comments by referring to the risk of him "regressing". This is grist to the mill for a provocative therapist. Farrelly responds with a series of statements designed to 'turn up the heat' between Bill's dilemma of chronic hopelessness and sudden self-affirmations in response to the therapist's paradoxical repositioning.

"Well, if I've been of any help to you and you're showing any kind of progress, you're moving with all the speed of a turtle encased in concrete."

"Yeah, I can see you now, as we go on and on towards the second 91st interview. You'll probably 'regress' more and more as you keep saying, until I'll be feeding you your Pablum like a tiny baby."

"…… finally by the time we reach the next 91st interview you will have made medical history." The patient looked puzzled and asked cautiously, "What do you mean?" I answered, "Well, hell, Bill, if you can continue this 'regression' like you keep saying, by that time you'll be the first neonate on record with pubic hair" (Farrelly & Brandsma, 1974, pp. 26-27).

Creating tension 2: therapist defending or exaggerating a problem behaviour or symptom.

Greenwald (1985) describes a session with a female client who "was very depressed and was able to transform any triumph into a disaster". One time she forewarned Greenwald that she was going to be especially depressed at her session on the following day.

The next day she came in her depressed clothes. She had a special costume. Ordinarily she dressed well, but this time she came in a dark, shapeless dress.

I sat in the corner and appeared very depressed. She started to talk to me and as she talked, I started to sigh. This went on and on. I was beginning to enjoy it because I'm hardly ever depressed and here I was letting myself be depressed. Finally, she stopped and said, "You know, Dr. Greenwald, when my last analyst didn't feel well, she would cancel the session".

I said, with my voice quivering, "Yes, I suppose I could have done it, but what good would it have done? You're only going to die anyway" (which is what she would always say).

We went on a little bit more in this manner. She didn't like my depression and she kept working on it, trying to get me angry. Finally, she stopped and said, "I know what you're doing you son of a bitch. You're showing me how miserable I am. How do you put up with me?" Thereafter, the session went much better (p. 238).

A couple of years after having heard Greenwald's description of this encounter, I had a very similar client who would also turn up to therapy in her depressed outfit on the days she felt especially miserable, which was most of the time. On recalling Greenwald, before one appointment I allowed myself effectively to sink into a mild state of dread as I awaited her arrival. After an initial muffled, "Aahh, you managed to get here then", sighing deeply and loudly I sank into my chair. She sank into her chair and sighed. This continued for ten minutes. We were in harmony. The more one sank and sighed, the more did the other. Eventually, the client asked "So what will we talk about today?" Grateful for her lead I responded with "Why talk about anything, we're all going to die anyway" which was, as with Greenwald's client, the sort of thing she would have said. In her frustration she began to try to make me feel better while responding to the humour of the situation. The more she tried to make me feel better, the more I burlesqued being depressed and beyond help. Finally, laughing, the client spluttered "You're not really down, you're pretending to be me you bastard!". I am proud to confess that, while she began to process this experience with a re-evaluation of her habitual tendency to become depressed, I continued to whine, whinge and sigh, muttering that it was all very well for her to be re-evaluating her way to deal with life but what about my needs! For good measure I threw in a couple of profound ironic proverbs such as "we can transform any negative thought into an even worse reality" and "whenever you feel a positive thought or feeling coming on, lie down and let it pass". The use of humorous and ironic proverbs and affirmations is discussed later in this chapter in the section on indirect interventions.

At this point, it is worth noting that the therapist's behaviour could be deemed as unreasonable and perhaps irresponsible. I will always remember her parting statement at the conclusion of that particular therapy session. "You're a bloody idiot and so am I, but you're just pretending and I don't have to be." I confess to having been a little anxious awaiting the next therapy session with this client but relieved with her opening statement of "You held a mirror up to me,

you bastard, and I've had the shits with what I saw all week" at which we both burst into laughter.

Creating tension 3: therapist understating, oversimplifying or over-clarifying the client's problem.

Understating or oversimplifying clients' problems seems to be useful with clients who are already doing this themselves as a way to rationalise their behaviour or avoid doing something about it by convincing themselves the problem is not really a problem. This is particularly common with people who have addictive or compulsive problems, such as substance abuse and eating disorders. Here are some statements I have made to clients with alcohol problems and bulimic clients.

Alcoholism

- To a client who was clearly alcoholic but denying that he was, preferring to describe himself as having "a bit of a problem with the booze", I said "well of course you couldn't be an alcoholic because if you were you'd have to go to all those boring fucking meetings".
- There would have been some people who'd consider their daily alcohol consumption light compared to yours, that is if they hadn't died from cirrhosis of the liver already.

Bulimia

- I told one client she could market her eating behaviour as 'Mary's Gorge and Purge Weight Loss Program'. No food restrictions, eat as much as you can, as often as you can. No need to feel humiliated in public weight loss programs, you can do Mary's program totally in secret and can feel as humiliated as you need to in the privacy and security of your own toilet.

Creating tension 4: getting the client to lampoon their own behaviour by practising it in an exaggerated or mocking manner.

A number of the interventions in this category, including this one, are similar to established paradoxical and strategic therapy techniques discussed in subsequent sections of this chapter,

such as prescribing the symptom in strategic therapy and Dunlap's practising the symptom. The question is whether or not more tension can be created when clients perform these tasks in ways that allow them to mock and lampoon their behaviour through exaggeration. The humorous aspect arises, in part at least, from clients acting out things that have been bothering them in different ways that allow them to poke fun at themselves.

In *The Little Book of Stress* (1996), Kaz Cooke playfully recommends humorous and paradoxical examples of dealing with stress by becoming more stressed. She is poking fun at stress management self-help books and implying ways to deal with stress by doing the opposite of what she suggests. As she explains in her introduction:

I don't know about you, but all those little books of deadly-serious, one-thought-per-page, calm-down-this-second, hippy-drippy nonsense make me really tense. After all, who's more likely to get along in life: the wafty hippy idiot, or the person who can handle some of life's stressful realities? …….. Follow the recommendations in this book and you will be very practised at all of life's most angst-ridden moments. You'd also be stark raving bonkers. To be perfectly frank, these suggestions are like camouflage-print condoms: **you're not meant to actually TRY them**. And remember, if you really want to be calm, just reverse all the suggestions (1996, no page numbers in original, bold print in original).

In fact, versions of several of the activities she suggests can be used in therapy to produce tension and paradoxical reactions. Here is a small selection of Kaz Cooke's suggestions followed by similar activities I have used with individual clients, in group settings and as absurd homework.

Here's a good exercise. Place your head between your knees, cover your face with your hands and rock slowly back and forth slowly, chanting, "Oh my God".

Simply getting clients to do this can be quite personally confronting for them but with a humorous attitude can also be a trigger for self-awareness and distancing from the behaviour. The previous descriptions of Greenwald and myself mirroring our clients' depressive behaviours are therapeutic applications of this.

Every day take some time to sit at your desk, breathe deeply and say to yourself: "Have I left the iron on?"

I have used this theme with obsessive compulsive clients in which humour and incongruity are attached to the obsessional thinking ways are found to perform the compulsive behaviour differently. A client saw me who had a compulsion to check he had switched off light switches, even when it was obvious he had such as when standing in total darkness. He had to check each light switch four times. I asked him to increase the number of times he checked each switch to five that night, then six the following night, then seven and so on to twelve times for each light switch and to return to see me on the day following the twelve checks night. He reported having had a lot of difficulty checking each switch so many times and that it was taking him a long time to get to bed as a consequence of this. I asked him to reduce the number of checks that night to eleven, ten the following night, nine the next and so on until he was back to four times. I organised an appointment for the day following the four checks night. He reported being sick of checking light switches to the point that he had even been frustrated with having check each one four times the night before our appointment. I told him he had a choice from this point. He could reduce to three, two, one before building back up by one check per night to twelve or he could simply start from five again that night. Reducing to one would mean that he was doing the 'homework' for an extra six nights than if he just started from five again. I could tell that he was becoming a little oppositional to my suggestions that he continue with his excessive and time consuming light switch checking. He asked why he could not reduce to three or two or one and see if he could stay with that as he did not feel the need to check four times, let alone twelve, any more. I told him I did not think he was ready, that he just thought he was because he had become sick of checking so many times. I wanted him to rebel against me because he had always been so compliant and unaware that he could resist, not only other people's unreasonable demands on his time but his own. On the first night he fought with himself and eventually settled on three checks. He phoned me a week later to advise that he had stopped checking after the first night and did not need to see me any more. I called him a few weeks later and he reported having remained symptom free, stating that "I guess I must have just grown out of it".

If you're too relaxed, tighten up every part of your body slowly. Now, hold.

Progressive relaxation is a technique often taught to people as a means to promote the relaxation response when feeling tense. It involves tensing the muscles in a specific part of the body for a few seconds and letting them relax and being aware of the sensation of relaxation that ensues. The person moves progressively through the body either from the top of the head to the toes or vice versa. This can be self-applied by a person individually or by a group leader talking a group of people through the process. Kaz Cooke's version burlesques this procedure while also highlighting how people can naturally intensify tension, both physical and psychological, in themselves. A man came to see me for assistance in becoming less tense. A previous therapist had taught him progressive relaxation but he stated that he found it to be unhelpful or even making him more tense. I asked him to go through the technique and observed him visibly becoming more tense within a couple of minutes of doing this. I asked him to stop and to describe to me how he was talking himself through the relaxation process. His previous therapist had told him to say, mentally not out loud, "relax" on each out-breath. He was a hard task-master on himself, a major reason why he suffered so much with tension, and would quickly turn his mental suggestion to "relax" into the command "RELAX NOW … OR YOU ARE A FAILURE!" which led inevitably to resistance, more tension and failure. I had him systematically intensify his muscle tension while debating the pros and cons of being relaxed during which I would mostly side with the argument in favour of staying tense. An interesting feature of these sessions was that the arguments became more ridiculous, frequently resulting in both of us laughing hysterically, leading to his realisation that his old tension habit would become neutralised by laughter. From then it became easy for him to associate his tension with laughter and the awareness that becoming tense was absurd.

Write down a list of all your most intimate worries. Chant the list hourly until you become unconscious or rigid with horror.

This is something people do a lot of the time. Cooke's suggestion is merely an exaggeration of how people ruminate on their problems anyway, a major cause of sleepless nights. Reason would guide therapists to train clients in alternative cognitive patterns whereas absurdity, in the

form of paradox, intensifies their old habitual cognitive patterns hopefully to a point where they are overwhelmed by how ridiculous they are being.

I have asked obsessionally negative clients to catch themselves each time they are having a 'black thought' during the day, jot down the essence of it in a notebook, and then let themselves move beyond it because they are allocated an 'intensive black thought session' later on each day. They identify an appropriate time each day when they can go through all their noted 'black thoughts' but as they are squeezing them all into a limited time, usually a half hour, they have to concentrate intensely and exaggerate them substantially so as to process them all in the brief allocated period. Typically, people report being unable to maintain such an intense focus and their negative cognitions have less impact during the day as they are being witnessed and externalised by being noted.

Communicate by whinging, shouting and using aggressive gestures. This will clear the room in no time and leave you in control. Being in control, even of an empty room, is terribly impressive.

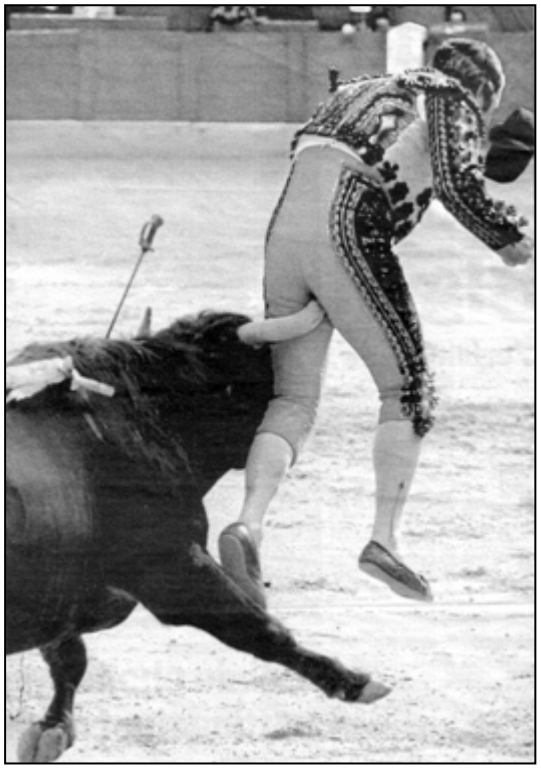
Sometimes a heavy dose of reality testing is the quickest way to awareness of the effect one is having on others. In therapy, clients might be asked to describe how they behave in company or they might be asked to role-play how they behave. In absurd therapy, they might be provoked to exaggerate these behaviours or they could be subjected to the therapist mirroring, perhaps lampooning, their behaviours. I have often presented clients with the dilemma*: "why suffer in silence while you can still moan, whimper and complain?"*

Creating tension 5: therapist challenging the client, perhaps having a bet with the client, to let them prove the therapist wrong.

This arises from the assumption that people tend to rise to a challenge especially when doing so will show a person with some sort of authority, status, power to be wrong. I have occasionally had bets with clients, who are clearly on the road to recovery, that they are going to relapse or at least not maintain their progress. An example of this is my bet with the recovering bulimic teenager described early in this chapter.

Creating tension 6: therapist intensifying the polarities of a dilemma being experienced by the client.

This can be a way to leave a client with tension between the polarities or used to provoke a polarity response, in which case it would fall into the classification of provocative interventions. As observed by Ivey et al (1987), the majority of approaches to psychotherapy include mechanisms by which to confront clients' dilemmas, discrepancies and incongruities. They present confrontation as a counselling technique by which to expose "discrepancies between or among attitudes, thoughts, or behaviours" for example by stating to the client that "On the one hand, you think (feel, behave) …, but on the other, you think (feel, behave …" (pp. 84-85). This is an example of a reasonable way to increase tension by highlighting discrepancies in what the person is thinking, feeling or doing. Absurd therapists might simply take on the role of one aspect of the dilemma and play with it or push it to an uncomfortable extreme, or launch into a satirical role-play of each aspect, or get the client to take each aspect to its logical (or illogical) extreme. We are all at times caught on the horns of a dilemma. How we take on each of those horns is the critical factor. I have emphasised this point with clients by showing them the photograph, on the following page, I found some years ago in the *Sydney Morning Herald*.



Creating tension 7: therapist focusing on the client's taboo topics.

Where topics are being avoided or prohibited by the client but, in so doing, they become even more problematic for the client or for the therapy, therapists (both reasonable and absurd therapists) will tend to make them explicit in therapy. The difference between reason-based and absurd therapy is how, rather than if, taboo topics are made explicit. Rather than, or as well as, having the client experience emotional pain while dealing with the hitherto prohibited difficulty, the absurd therapist wants the client to be amazed by how ridiculous it is and to laugh at it. Taboo topics dealt with in therapy usually relate to sexuality or fear and, though they may also be societal taboos, it is when a client's problems are arising from his or her own prohibitions, rather than from other people or 'society', that they are likely to become targeted by the therapist. Farrelly describes the therapist's task as:

…to *express the unutterable, feel the unfeelable*, and *think the unthinkable* with the client, verbalizing all the client's implicit doubts, echoing the client's worst thoughts and fears about himself and about the reactions of other people toward him (Farrelly & Brandsma, 1974, p. 58, emphasis in original).

One of Farrelly's case examples demonstrates this. He begins by describing the initial session with a depressed married female inpatient in a psychiatric ward. The interview was held in the presence of some of the ward staff. As the patient is not forthcoming with what has been worrying her, Farrelly first goes on a "fishing expedition" bringing up a number of possible concerns, none of which appear to be the source of her depression.

T. (*Wearily*.): O.K. Gorgeous, if you're so neat and competent and lovable in all these areas, what are you so depressed over?
Pt. (*Looking down, pauses*.): I don't want to talk about it.
(*What went through my mind was: Ah, ha, she's held up the red flag: Stop! So I decided to charge*.)
T. (*Triumphantly*.): It's sex!
Pt. (*Louder, looking up, angrily*.): I told you, I'm not going to talk about it!
T. (*Smugly*.): I see, you're ashamed you're a prevert! *(sic*)

Quite briefly, it soon became clear what was causing her depression: she had had "dirty, preverted *(sic)* thoughts, feelings and desires" but was very ashamed of them and was scared to tell her husband because "he would be shocked to death". The therapist made fun of her feelings regarding this and role modeled disgust and aversion to her desire to engage in oral and anal sex and experiment with any number of different positions at various times of day and night.

T. (*Incredulously*.): You must be a sex maniac. How often do you have sex?
Pt. (*Muttering*.): Three times a week over the past 14 years.
T. (*Pauses; does some calculating*.): Well that's almost 2200 screws over the past 14 years. How many orgasms have you had?
Pt. (*Grimly*.): Five!
T. (*Surprised*.): Five? How do you know?
Pt. (*Again with assurance*.): Because I *counted* them.
T. (*Still questioning*.): Sure?
Pt. (*Firmly*.): Absolutely!
T. (*In a laughing aside to staff*.): That's a pretty thin reinforcement schedule as the operant conditioners would say.
(*Group of staff observers in the room burst out laughing along with the patient and therapist*) (Farrelly & Bransma, 1974, pp. 184-185).

Her husband attended the second interview and is told by Farrelly that his wife is depressed because "she has a lot of dirty, sexy feelings and thoughts and desires about you which she feels unable to express." When the husband shows keen interest in what these desires might be, therapist, husband, staff and even the wife (while "blushing furiously") burst into laughter. When husband and wife agree that, in Farrelly's words, during sex she "laid there like King Tut's mummy while he does it to you", Farrelly advises her to assist her husband in his attempts to sexually arouse her by masturbating and fondling her breasts during intercourse. He adds:

Put your hands where they'll do the most good - and that's not on his back, unless *you* have an erogenous zone between *his* clavicles (p. 185, emphasis in original).

As the wife confesses that she had thought of these things herself before but had felt they were "abnormal", Farrelly asks the husband if he will "get disgusted with her and vomit all over her if she helps you get her aroused to orgasm?"
The husband, "who was almost drooling by this time", is convincing in his assurances of a positive response to her assistance and asks if she can be allowed home for a few days. Farrelly agrees but only with the condition that they do some 'homework'.

I want you to do three things: 1. Fuck! 2. Fuck! 3. Fuck! You have four days to do it in, and I'll see you Monday evening.

The following Monday the patient and her husband were seen along with the staff observers. Quite briefly, she had equaled the frequency of the past 14 years in 4 days and experienced 5 orgasms in 7 acts of intercourse (p. 186).

Creating tension 8: therapist frustrates or blocks the client's rationalisations and intellectualisations.

Some examples of this group of therapist behaviours are to frustrate clients by listing their problems in an exaggerated manner; debate lots of contrasting explanations or theories about their behaviour; the therapist constantly shifting position or changing her mind; to overwhelm or interrupt clients' irrational rationalising; and to lampoon clients' "why" questions by offering ridiculous explanations.

For example some people can become so over-dependent on finding intellectual explanations for their problem that their search can be an obstacle to doing something practical about dealing with it. I have often worked with clients who constantly come up with elaborate explanations for their behaviour and then seek confirmation from me about the validity or otherwise of each one. The need to seek meaning and make sense of experiences is a normal human trait but in these cases has become a smokescreen against understanding that freezes the person into an inability to act. In these cases I often simply agree with every explanation offered for validation and even throw in a few questionable ones of my own. This frequently leads us into absurd debates about the comparative usefulness of what become increasingly untenable theories about the clients' situation. Similarly I might offer a series of incompatible explanations during a session or over two or three sessions. When clients challenge this I'll respond with comments such as "I've changed my mind", "they all sound as good as each other don't they?" or "well mine make as much sense as yours".

This approach is a good example of one of the implications of absurdity that multiple interpretations, 'realities' or 'truths' can be entertained simultaneously, which stands in contrast to reason's demand that ultimately there can be only one truth, at least at any one time. Frequently clients are presenting to therapy personal 'truths' or 'realities' that are in some way causing them suffering but their requested outcome from therapy is often relief from suffering rather than changing, or even challenging, their reality. Behaviour therapy is more concerned with relief of suffering through changing problematic behaviour whereas cognitive approaches to therapy, both reasoned and absurd, often do target clients' realities. Reasoned approaches challenge problematic interpretations in order to replace them with more functional ones. The issue here, in terms of power and demands to conform to images of 'normality' and reasonableness, is on whose criteria for functionality are the replaced interpretations based.

Absurd approaches to therapy are likely to play with and lampoon clients' realities but not likely to offer reasonable alternatives, and in some cases deliberately obstruct clients' attempts to do so themselves, at least during the session. The emphasis seems to be on stimulating a context in which clients can be creative about creating their own alternatives by seeing the absurdity of their old interpretations themselves. Does this reflect an assumption of absurdity, at least as an approach to change, that people are capable of, and better off, creating their own changes without guidance or reasons from others? It also refers back to the earlier question of whether change can only be radical or profound when it arises from within the person and can not be radical if stemming, or perhaps even influenced, from outside the person.

Farrelly presents numerous examples of therapeutic interventions aimed at frustrating clients' rationalisations. His explanation for doing this echoes my comments above.

> The main goal here is not to provide cognitive insights or explanations regarding the psychogenesis of their conflicts but to countercondition this fruitless quest for the golden fleece (Farrelly & Brandsma, 1974, p. 74).

He then gives an example from one of his sessions in which he presents to the client "contrasting high level of inference explanations with low level ones", presumably because she had been consistently presenting complex intellectualisations as explanations for her behaviour.

> Therapist. (*Puzzled*.): I can't figure out whether you are (1) *immoral* or whether you have learned self-defeating, acting-out, anti-social behavioural patterns of promiscuity; or (2) whether you are *weak* or whether you have a highly impaired ego functioning related to your significant early emotional deprivation; or (3) whether you are *lazy* or simply are chronically dependent and overwhelmed by feelings of inadequacy in task performance areas (1974, p. 74, author's italics).

Farrelly also gives examples of the therapist listing, in an exaggerated manner, aspects of clients' behaviour and rationalisations as a means to frustrate and provoke them into seeing the absurdity of what they have been doing. The following example is lengthy but well worth inclusion here in its entirety. His long drawn out listing of the client's behaviours and rationalisations becomes overwhelming for the client while also being ridiculous and eventually

funny as it leads into bizarre talk of corpses not worrying about "crotch rot". The listing creates tension in the client and then relief through laughter as she begins to shift her position on her behaviour and rationalisations. The client was a young woman with a history of serious suicide attempts one of which left her in intensive care in a coma for two weeks after swallowing 300 tablets. Given her history, this vignette is also an example of what Vorhaus calls 'the will to risk' as described earlier.

T(herapist). (*He has his feet up on the table, puffs a cigarette while sipping coffee; speaks throughout in a laconic, almost droning, soul-weary voice.*): Wouldn't it be beautiful? With just a little effort, with just a little bit of pain, with just putting 300 more pills in your mouth, or just one pull of the trigger, or just that quick snap of the rope around your neck and a few minutes of choking, or just that one more leap from the fifth story window – and make sure this time you don't land in the bush, but on concrete – wouldn't it be easy? And then, no more wondering if you're pregnant for the fourth time and have to give yourself an abortion with knitting needles; no more calling yourself sexually rotten because you fucked five guys last week and that brings that actual total up to 1005; no more having to cut yourself to prove God knows what; no more having to go through your elaborate mental gymnastics to get them to screw you and hurt you so you can feel almost elated though sore down there (*he points at her crotch*) the next morning; no more feeling depressed on gray, chilly, rainy mornings like today (*he points over his shoulder out the window at the windswept rainy landscape.*); no more wondering if you can pass your courses in this new training program you're going into; no more anxiety about what will my Mamma and Daddy think of me; no more being bothered by your weird so-called friends at all hours of the day and night; it would all just be beautiful, wouldn't it? To have the deep, long sleep. Isn't that a real, constant temptation? (*the patient glances up and nods almost imperceptively.*)

And you know, once they lay you to rest down deep in that warm, soft earth, there's no more hassles from the finance company; no more wondering how you're going to finance your new training program; no more wondering about whether to screw or not; no more of these interviews which you say you hate but you've been coming to with clockwork regularity for the past two years; no more getting your feet wet (*Therapist points at client's wet shoes.*) on raining chilly mornings; no more having a sore twat for having screwed five guys 17 times in one week; no more having to make up lies to your parents about how things are going down here in the city; no more decisions, no more worries. Corpses and cadavers don't worry about the scars on their body (*T. points at her scars.*) or what other people think of them, or how they will pay their bills, or are they knocked up – corpses don't get pregnant, research has proved that conclusively; corpses don't worry about having crotch rot – their whole body is rotting out; and corpses don't have to answer questions that therapists pose that make them anxious. Corpses, Sweetheart, (*therapist bends over and gently pats her knee.*) corpses don't get anxious at all. They're just calm, peaceful, and it's sleep, sleep, sleep.

C(lient). (*Has sat throughout this, looking at the floor, her lips in a tight grimace, her elbow resting on the arm of the chair and a hand to her forehead. She finally looks up and mutters something.*)
T. (*In the same quiet, almost droning tone of voice.*): What was your response, Gorgeous?
C. (*In a slightly louder tone, but still almost inaudible.*): I said, Shut up, I don't want to hear all that!
T. (*Smiling warmly; in the same soft tone.*): But you thought it and felt it all, haven't you? Many times over?
C. (*Looking steadily at therapist, in a level tone.*): You know goddamn good and well I have; but do you have to keep listing, listing, and listing them?
T. (*In a "sweetly reasonable" tone; leaning forward.*): Well, Sweetheart, you think them, you feel them, so why the hell not say them out loud?
C. (*In a much louder tone; forcibly.*): Goddamn it, I'm not going to commit suicide. That's enough of that shit!
T. (*Leaning forward, stroking the patient's knee almost seductively; very "supportively".*): But, Honey, Sweetheart, Baby, you could always do it, just remember that. It's sort of your trump card, isn't it? It's always your way out, isn't it?
C. (*A Kaleidoscope of feelings crossing her face; she smiles, grimaces, andshe puts her hand on her forehead, leans back in the chair and stretches for a number of seconds while saying.*): Noooooooo, I'm not going to do it, not really. I've developed too many inhibitions.
T. (*Leaning back in his chair, guffawing.*): You?! Inhibitions?! Aw, come on. Now I'm told you fucked 15 guys in the last 10 days, is that right?
C. (*Leaning forward, grinning embarrassedly,* (sic) *pounding her fist on the desk.*): I did not! It was only five!
Therapist and patient laugh together (Farrelly & Brandsma, 1974, pp. 80-82, author's italics).

PLAYFULNESS – THE CLOWN OR THE COMIC – therapists being spontaneous, playful, comical, playing the clown, not shackled by adult sensibilities.

As discussed in the section on playfulness in the previous chapter, the aspect of absurdity in therapy being addressed in this thesis is 'playfulness', in the sense of being 'frolicsome' and 'pleasantly humorous' rather than 'play' as a structured or rule-based activity. Similarly it is concerned with therapists being playful in their sessions and is not about therapists doing play therapy. Some clarification may be useful here. Play therapy is a broad concept that refers to indirect approaches to therapy in which clients, usually children, deal with issues by being one step removed from them through play. Like play, play therapy is purposeful though it can be either open ended and non-directive, in which the client initiates activities and discussions, or more structured and directed by the therapist. Play therapy sessions are not based on humour or spontaneity, though these do arise during sessions, especially non-directive ones, and tasks

within a session are often delineated, goal-directed and mostly linear though they are usually designed to provide opportunity for creativity, laterality and new understandings.

Some writers argue that psychotherapy generally should be seen as a form of play and be a means by which people can become more playful. Not surprisingly such calls are often made by therapists working with children. Even child therapists with a psychoanalytic orientation have suggested this, such as Winnicott:

> Psychotherapy takes place in the overlap of two areas of playing, that of the patient and that of the therapist. Psychotherapy has to do with two people playing together. The corollary of this is that where playing is not possible then the work done by the therapist is directed towards bringing the patient from a state of not being able to play into a state of being able to play (1974, p. 44).

Carl Whitaker presents play therapy as a paradigm for family therapy. After describing a therapy session that moved from being cautious and awkward to "free-flowing" and "gratifying" when everyone – children, parents, therapists – began playing with toys, he states:

> We had been doing play therapy with the whole family. The open ended, nonrational quality of this interview is the quality of psychotherapy that interests us the most. While we steer away from abstract, theoretical descriptions of psychotherapy theory and technique, there are patterns which emerge in our work which we try to conceptualize. Lately, we have been intrigued by parallels between the process of play therapy and family therapy (Keith & Whitaker, 1981, pp. 243-244).

Whitaker brings the concepts of 'play' and 'playfulness' closer by putting therapists' playfulness within a certain context with limits and rules regarding which behaviours are deemed appropriate and which not so. This idea of context-defined playfulness is relevant to the distinction in this thesis between therapists using absurdity as technique or therapists simply being absurd during a therapy session. It would be a dangerous argument that therapy should have no limits or restraints on therapists' behaviour, but that is not to say that therapists should always be operating consciously according to prescribed limits or rules either. Evidently Whitaker would come up with impulsive acts of absurdity with no obvious connection to what is occurring in the therapy session, as described by his co-author and co-therapist David Keith.

One of my favorites is the time that Dr. Whitaker left the interview room, then came back a while later and sat down. The husband in the family asked why he left. He replied, "My foot itched." And the interview continued (Keith & Whitaker, 1981, p. 251).

Playfulness as a component of a therapy session can occur as a brief activity, such as with the use of humorous props, telling jokes or playing a children's game as described in this section, or can be a comprehensive activity such as dressing up for a session, an activity seen in its extreme in the example described below of agoraphobics going to a shopping centre wearing clown disguises and outfits stuffed with balloons.

Being playful 1: dressing up (or down).

In the previous section on creating tension I described how two clients would turn up for therapy sessions wearing their depressed outfits to communicate, to themselves as much as to the their therapist, that they were feeling especially down on those days. A reasonable therapist working with someone who typically wore tragedy clothes would probably try to guide them into dressing in a brighter or at least less mournful way. The absurd therapist will probably insist on clients wearing tragedy outfits even (especially) when they are feeling fine, or ask them to dress even more tragically than they have been doing, or urge them to dress in more bizarre ways. When these clients wore their tragedy outfits they were emphasising their suffering in a negative self-defeating way. Coming to therapy dressed this way was effectively a self-double-bind. "I want you to help me feel better, but how could anyone who looks this miserable ever feel better?" The point in therapy of exaggeratedly dressing up as one's problem is for it to lead to dissatisfaction, a sense of incongruity, with that problem creating a format in which the absurdity of maintaining the problem can be experienced.

Similarly, dressing up in one's 'glad rags' can highlight dilemmas and lead to habit-breaking responses. As a component of their homework, I have sometimes suggested to bulimic clients that when they feel a binge-purge coming on they dress up for the occasion in their sexiest, most special, going out to sweep them off their feet, outfit. This incongruous clash of behaviours

highlights the extremes of the messages they give to themselves and consequences for their self-image. Having to dress up also interrupts an otherwise automatic pattern of behaviour and provides them with a means to postpone voluntarily what is usually an immediate impulsive act experienced as beyond self-control. In describing an awareness that arose from doing this exercise, one client said "it seemed weird, then it hit me that it's a weird thing to do whatever I'm wearing". Dressing up for the binge-purge, as with many pattern interruption strategies, also provides the person with an opportunity to put off or, better still, decide against doing the problem behaviour, perhaps by doing something else instead. When the aforementioned client, dressed in her nicest dress and dancing shoes, became aware of how weird her bulimic behaviour was, she phoned a friend and persuaded her to go out dancing with her, a considerably more enjoyable and normal thing to do than binge-eat and then vomit.

In one of my workshops, a participant, a mental health professional, described his team's use of comical disguise in a treatment program for agoraphobics. Subsequently, I have used this in training workshops and with clients. Full body suits are made from an elastic stretchy cotton material. People put these on, they are filled with thirty to forty blown-up balloons, and, in my workshops, they then run at, into, on top of, and over each other, bouncing off, balloons bursting, people in hysterics. If someone falls on the floor they are physically unhurt because they are protected by all the balloons but they suffer (in laughter) the indignity of being unable to get back on their feet as the balloons keep them so far off the floor their feet are waving uselessly around in the air above them. In the agoraphobia program, clients would dress up in the balloon suits, paint clown faces, put on clown wigs, noses and oversized shoes, and en masse visit a shopping centre, most agoraphobics' greatest source of fear, where they would joyfully bump into shoppers, innocently bouncing off them inside their protective balloon protective camouflage. Such an absurd and humorous context brings about positive responses from the public and while facing their greatest fear the agoraphobia sufferers are able to produce laughter and positive responses from strangers. I have also used these suits in groups dealing with problems with assertiveness and issues with body image.

Being playful 2: playing children's games.

As with Carl Whitaker's example above, one way to stimulate playfulness, in adults as well as children, is through children's play activities. In his example the whole family sat on the floor and played with children's toys. Similarly, adults, as well as children, can be enticed into playing childhood games, such as marbles, pitching pennies, skipping, hopscotch, and hide and seek. I have played childhood games with clients in individual therapy and have had whole groups playing them in group therapy. Children's games are even being played in the workplace and boardrooms.

One simple strategy for organizing a break is to play your favorite childhood games, especially at a crucial time during a taxing project. Peter Frid, assistant general manager of KTOO-TV in Juneau, Alaska, was part of an endless fund-raising meeting chaired by Don Rinker, president and general manager of the station. After hours of difficult financial negotiation, Don looked around the room and saw glazed, bloodshot eyes staring back at him. He firmly announced, "We need a break!"

Don dragged Peter out into the hallway and challenged him to a game of pitching pennies. When the two of them got down on their hands and knees they stopped thinking about raising hundreds of thousands of dollars for the station. Their concern was more immediate – who would win the next penny (Weinstein, 1996, pp. 119-120).

At another organisation, after a game of marbles spontaneously organised to avert a "stress explosion" of staff working to a tight deadline, the comment was: "The best thing was that nobody really remembered how to play, so we just got down on the floor and made up our own crazy games. It was more about laughing and being together than winning or losing, and it was just what we needed" (Weinstein, 1996, p. 120).

Other games to have been found to work both in therapy and workplace settings are the card game 'snap', charades and pictionary, and hide and seek as a group activity. In one workplace in England, the old British game of shove halfpenny, in which a small coin (traditionally a halfpenny but these days usually a one pence piece) represents a ball and is impelled by larger coins around a desk-top pitch, became so popular as a lunchtime activity that staff developed competition league tables, divisions one to four, for it and each player made up football team names for themselves from their surnames. Sandwich chomping crowds would gather around desks to watch the likes of The Harrison Hotspurs take on MacDonald United.

Being playful 3: photographs.

A group therapy or workplace activity is for each person to bring in a photograph of him or herself as a baby and mount them all on a notice board. These remain anonymous for a while with people trying to guess which photo is of which person. Workplaces in which this has been done often leave the photo gallery in place even after everyone has been identified, perhaps as a reminder that they are all human and were (are) all essentially the same at heart irrespective of position in the hierarchy as an adult.

A reasonable way to use photographs in therapy is to get clients to photograph their high points of the week, the things they did well, their enjoyable times and then look at what made these experiences good and work out ways they can make this happen more.

A paradoxical approach would be to get clients to take photographs of the week's stuff-ups, the disasters, fears and phobias, arguments, negative states, and perhaps also make up a collage from the photos. From this recording of negativity or 'crazy' behaviour, clients can be invited to reinvent their week, identifying different ways to have dealt with situations and even making fun of the difficulties they did actually encounter. This reinventing of the week would usually be a quite rational process. A paradoxical aspect of this intervention is having clients choose to face their problems, initially in a sense one step removed through the camera lens, and then more directly such as by talking about it or role-playing it. Facing a fear can be the first step to

overcoming it. Typically people try to avoid a fear stimulus, or run away from it, thereby usually ensuring the object of fear's survival as an ongoing power over the person.

The example just given combines absurdity (photographing the problem) with reason (working out how it could have been dealt with differently) but there are also therapeutic approaches in which reason plays no role. With paradox, clients can be asked to continue to play out their problem, perhaps with heightened awareness of how they are doing this or attaching an incongruous added behaviour to it. The enhanced 'doing' of the problem can be the mechanism leading to change irrespective of whether or not the person processes what is happening in any rational way. Examples of these can be found in the subsequent section in this chapter 'Paradoxical and Incongruity-Based Strategies'. With humour, problems and clients' roles in maintaining them are lampooned, exaggerated to their ridiculous extremes, or caricatured visually, for example as cartoons, or verbally, for example through funny songs, limericks or jokes.

Being playful 4: jokes and funny stories.

There are numerous ways in which jokes can be introduced into a therapy session by either therapists or clients. I consider therapists telling jokes to clients as an example of absurdity in therapy where reason should play a role as there is a risk that clients can feel demeaned or trivialised, or the joke can simply be inappropriate. Although this is a potential risk with all approaches to therapy, both reason-based or absurd, I believe the risk is greater in joke-telling and therefore therapists using jokes should consider the appropriateness and potential impacts beforehand.

Therapists sometimes tell jokes simply to defuse tense situations and provide some temporary relief to clients when it is helpful to do so. Numerous sources also advocate the use of jokes as a component of mental health assessment, as summarised by Buckman (1994, pp. 15-16). The more potent role of therapists telling jokes is where they act as a kind of metaphor allowing clients to see an absurd aspect of their problem, responding with laughter at this and thereby at

themselves. I told the following joke to a client who was frequently drinking himself into extreme drunkenness, unruly behaviour and often passing out in public places.

A man, obviously extremely intoxicated by alcohol, staggers into a pub and in a drunken slur asks the barman for a double whiskey. The barman refuses to serve him as he is so drunk and asks him to leave his pub. The drunken man staggers out, around the block, and back into the same pub, again slurs out his request for a drink only to receive the same response from the barman. Once again he staggers around the block and back into the same pub at which the barman yells at him never to come into his pub again. For a fourth time the he staggers around the block and stumbling up to the bar and seeing the same, now enraged, barman, he blurts out "Do you own all the bloody pubs in this neighbourhood?"

Clients can be asked to bring to therapy their favourite joke or funny story and sometimes they will spontaneously recall and tell a joke or funny story during a session. This is often an indicator of a changing relationship with their problem or shifting attitude towards themselves. This is most significant when clients come up with jokes associated with their own problems, as in the next case vignette of *Gore Galore*, and when they can tell to others funny and embarrassing stories about their own behaviour, as in the second example of group therapy with bulimic clients.

The *Gore Galore* client was a woman who had been involved in a car accident in which she had sustained some serious but not permanent physical injuries and profound phobic psychological injuries that had been compromising her life and preoccupying her for several years before she had this absurd psychotherapy session with Frank Farrelly. Other than the following sequences, this session has not been transcribed but I have a video recording of it that, with the client's permission, I have often used in training workshops. In the session she described a range of phobic fears that had been dominating her thinking since the accident and preventing her from performing numerous activities that had previously been simple for her. Farrelly depicted this as her own private horror show that consisted of dramatic images of her suffering violent gruesome death, such as in aeroplane crashes, plummeting elevators, buildings crashing down onto her, and being gored by sharks. Consequently she had become phobic of flying, could only use the stairs even where she had to get to the highest levels of skyscrapers, had anxiety attacks

in large buildings, and despite being a strong swimmer had not been in the ocean since the accident.

Throughout the session the therapist developed the client's images to the point of the ridiculous and steadfastly refused to let her shift awareness from them. He asked her to describe in detail where the shark first bites her.

Therapist. Can you imagine what it would feel like to have your leg bitten off – right above the knee? *(Therapist makes crunching sound as he points to her thigh.)*
Client. *(Looking very pensive and with serious tone.)* Yeh, I can.
Therapist. I thought you could. Where would it bite you first incidentally? Where? Would it take your head off first or go right across your middle? Which side would he eat first?
Client. *(Pensively.)* The head.
Therapist. Then your legs would be kicking spasmodically and just floating and then he'd come back for the other half. *(He grabs hold of her and snarls.)* I can hear your head crunching, blood dripping out the side of his mouth. God this is sickening.
Client. *(Looking intrigued while grimacing and laughing.)*

The client's responses are mostly a mixture of grimaces, and outbursts of laughter. She was laughing at her greatest fears. Suddenly, she announced that these gory descriptions had reminded her of a joke. She was shifting her position in relation to imagery that would previously have triggered a fear reaction but that she was now joking and laughing about. Here is the joke she told.

Two Irishmen are walking past a pub in Belfast when an explosion erupts inside and a man's head rolls out of the door. One of the men picks up the head and holds it out in front of them saying, "Jesus it looks like Patrick" to which the other man responds, "Aah, it does so, but it can't be him as he's taller than that".

The therapist then proceeds through each one of the fears described by the client, inflicting upon each the same treatment, finally getting to aeroplane crashes.

Therapist. Boy, when those things hit it's gore galore.
Client. *(With head in hands, laughing, quietly as though in disbelief.)* Gore galore!

Therapist. Its just splattered goo. Have you ever seen what a body looks like when it's fallen from a great height? It's just ooze. Can you imagine yourself looking like that? Boy, I'll tell you, you sure lose your toilet training if you hit like that. It's just piss, shit, blood, brain, snot, ear-wax plugs. *(Role-playing a rescuer.)* Hey, there are two plugs over there, 25 metres apart. *(Role-playing a second rescuer.)* Ear-wax. She hit so hard she really got her ears cleaned out but she never heard the thump.
Client. *(Is now laughing hysterically.)*
Therapist. *(Continuing to role-play rescuers, looking down and pointing to the ground in front of them.)* Eyes are just two wet spots. There's a pupil or something around here I think. It's a little flat.
Client. *(Now with tears of laughter pouring down her cheeks.)*
Therapist. What part do you think will hit first - your head or your ass? Did you ever see it? Never? I figure your ass would hit first. Drive your ass right up over your head. *(Arms pointing upwards and covering his face.)* We can't recognise her. Well pull her ass down from over her shoulders.
Client. *(Laughing loudly.)* It'd be like having plump shoulder pads.
Therapist. *(Still with arms pointing upwards and covering face.)* You had your legs sticking straight up past your ears and your ass was wrapped all around your face. *(Role-playing a rescuer.)* I think she hit ass first. You're gonna have to crank her legs down, then pull her ass down below her head and shoulders so we can identify her. Jesus she looks in a bad way. Looks dehydrated.

I caught up with this client a few months later and she reported that her symptoms had progressively diminished since the session. She described having bizarre and hilarious images whenever her horror images had recurred until they simply disappeared. She added that she had managed to fly home a couple of days after the session and laughed during much of the journey as she recalled Farrelly's suggested imagery and his role-playing. This session consisted of features from several of my classification, including surprise, creating tension, playful humour, and provocative therapy.

The example of people telling funny stories about how they have acted out their problems comes from a group therapy program for people with bulimia nervosa that I ran with a female co-therapist over a period of several months. Initially, as expected, group members, who had not met previously, were wary, fearful about being judged by others, and embarrassed about many of the things they had already done to 'feed' their bulimia. At the first meeting, all or most participants were concerned about appearing to be the worst bulimic in the group. In these groups, the co-therapists humorously, at first gently but increasingly provocatively, helped

draw group members out of their shells while also modelling that people can laugh at the serious (without having to detract from it). In the third or fourth session, group members were invited to relate their most embarrassing, or most bizarre, story about 'doing their bulimia'. By the fourth session they had switched from worrying they might be the worst bulimic to competing with one another for the right to be seen as the worst, but this was done with humour and the sense that they were all 'as bad as each other'. Paradoxically, these attempts to outdo one another created a sense of togetherness and empathy with each other as they discovered they all tended to be bulimic in roughly the same ways. I believe this process is inevitable with eating disorders if allowed to happen as the range of behaviours and cognitive patterns is quite narrow and stereotypical. They even came up with a humorous name for the group, 'The Duffers', an acronym for dumb, ugly, fat females, to poke fun at what they were beginning to realise were common self-images and body-images based on delusion and self-loathing. One group member went overseas for a month while the group was still meeting and sent a postcard that started with "Dear Duffers".

In the fourth session a 20-year old woman, who until this point had said very little, related her most embarrassing experience of being bulimic. She described having what she called a "mobile binge" in the foodhall at Sydney's Centrepoint. She spent a couple of hours plying herself with food from the many outlets until her stomach had become so distended that she looked nine months pregnant and could barely walk. At this point she threw herself out of the security of her chair and walked around the room protruding her stomach as best she could, which was not very much since she was quite slim and had not just binged. She described taking the elevator to the top floor of Centrepoint where there are public toilets. On leaving the elevator she passed by a seated security guard who, observing her apparent advanced condition, smiled sympathetically. After a half hour purge session in the toilet, she cleaned the toilet and herself and ventured out of the toilets, no longer appearing to be close to delivering a child but rather now being the slim young woman she normally was. With a mixture of grimaces and laughter, she related to the group her horror at finding the guard still sitting there, looking smilingly down to her stomach and how, as his look changed from sympathy to confusion to the beginning of shock, she leapt into the elevator and, fearing being chased by the guard and

police, ran as fast and as far as she could. On arriving at Central Station she jumped into the first train leaving which, as it turned out, was travelling in the opposite direction to home.

Being playful 5: props.

Props, such as toys, masks, plastic body parts, and balloons can be as useful with adult clients as they obviously are with children. As with other examples in this section on playfulness, props are often a means to access the child part of adults, in the spirit of Greenwald's 1967 article 'Play therapy for children over twenty-one' and Whitaker's play therapy paradigm, both of which are described elsewhere. As this is probably not the place to go into detailed presentations of how various props can be used in psychotherapy, I will simply provide a list of ones I am aware of, with brief explanations where necessary.

- Harmless objects that can be thrown at clients, by clients at therapists, and at each other in family or group settings, such as ping-pong balls, sponge balls, wet sponges, plastic body parts. I used to have one ping-pong ball in my therapy room that I would lob gently at clients' heads when I thought they had said something "dumb". One client complained, after the ping-pong ball had bounced off her forehead for the fourth time during the same session, that this was unfair. I reminded her that I only tossed the ball at her when I thought she had said something dumb. "That's not what I'm complaining about," she responded. "I don't mind being reminded by you when I am stuffing up. It's just that I should be able to do the same to you when I think you've said something dumb." I now have several ping-pong balls in my therapy room.

- Harmless objects people can hit each other with, such as balloons, rubber chickens, plastic hammers that make a silly noise when they hit something, sponge hammers or sponge fists as in de Nichilo's example described in the earlier section entitled Surprise/Unexpectedness.

- Comical body parts, often used to symbolise a personality characteristic or behaviour. Examples of these are plastic brains, hearts and feet, rubber head for squeezing when tense, chattering teeth and tapping fingers.

- Things worn on the face to appear comical, such as eyes on springs, spectacles with strange eyes painted on the eyepieces, Groucho Marx spectacles, nose and moustache, masks, clown noses. One day a few years ago when returning from visiting a friend who is a professional clown, my family and I became caught in a very bad traffic jam on Sydney Harbour bridge. My friend had given us an assortment of clown accessories including clown noses and grinning clown mouths. The traffic was at a standstill and people were grumpy, including two parents and their children of around four to seven years of age in the car adjacent to us. Suddenly, my six-year old daughter put on the nose and mouth and looked at the children in the other car who immediately burst into laughter and drew their parents' attention to the funny face. They smiled at my daughter. My wife and I noticed this and both spontaneously, without having conferred beforehand, also put on clown noses and mouths at which everyone in the other car burst into laughter. This was heartfelt, not demeaning laughing. We opened our windows, gave them four noses and four mouths, and both carloads bade mirthful farewells as the traffic began to move. My guess is that as they slowly progressed over the bridge they, like us, adorned their clown faces a few times.

- Objects that produce amusing noises or actions. Ones I have come across that can be used in therapy include a skull on a handle that laughs hysterically when it is shaken, a backscratcher that groans in pleasure when used, a little toilet that squirts water on a person when they lift the lid, singing fish, and a wind-up nun that spits sparks as she walks.

- An assortment of other props, such as magic wands, magic tricks, puppets, plastic food and plastic vomit (which I use with eating disorder clients), various massage devices, the balloon suits described in the introduction to this section, and a stretchy cotton tunnel that one person crawls through from one end and another from the other end encountering an interesting process of getting around each other in the middle. I also introduce juggling as a stress management technique with some clients. It is of course also an exercise in mastery and often a boost to self-esteem. I advise clients that I learned from a participant at one of my workshops that juggling should not be seen as relaxing because it requires a lot of concentration and is really quite stressful but "it is better to be stressed over your juggling

than about the nonsense you usually get stressed over". The recommendation is that whenever the person finds they are becoming overly stressed about some problem or other, juggle and stress over getting that right instead. Juggling can also be turned into a metaphor about control, concentration, recovering from errors and dealing with missed opportunities.

- Matt Weinstein, a management consultant assisting organisations to bring humour into their daily routines, recommends workplaces to have a 'stress support kit' that could contain items such as pens in the shape of vegetables, wind-up chattering teeth with little moving feet, a red foam clown nose and an anti-stress audiotape (1996, pp. 151-152.). Joel Goodman, the founder of *The Humor Project* in the USA, refers to a similar idea that he named 'mirth-aid kit' as a metaphor for the standard 'first-aid kit' required in workplaces (1997, p. 1858). Other potential components of a mirth-aid kit are clown noses, ping-pong balls, juggling balls, various neck and shoulder massage devices, and photos of staff as babies. Cartoons, a couple of good comedy audiotapes, a selection of good jokes, and one of the various simple devises now available that produce realistic sounding 'farts', some of them by remote control, could be appropriate. The kit could also include a selection of reminder quote cards, such as "a smile is the shortest distance between two people" (Victor Borge) and "you can't have everything, where will you put it?" (Steven Wright). Weinstein reports that the kit in his own workplace contains the following instructions.

  If you're taking yourself too seriously, it's time to lighten up already!
  Indications: For temporary relief of clenched teeth, tight necks and muscles, hair about to be pulled out by the roots, and general cranky behavior – all associated with the common stressors at work, at home, in traffic, on the golf course, in long lines …
  Dosage: Use as often as needed at the first sign of discomfort (pp. 151-152).

Being playful 6: group therapy.

Group therapy offers the absurdity-inclined therapist/facilitator an opportunity to stimulate group members to become comical and humorously provocative with each other, such as with the bulimics group referred to earlier in this section. Group contexts can also provide environments in which people are able to have fun with one another in ways that help them

break through old patterns and behave uncharacteristically and spontaneously, such as with the use of balloon suits described earlier. Farrelly describes a group setting in a psychiatric ward in which the therapist influenced an unusual group response to one of the group member's persistent behaviours.

A paranoid schizophrenic patient (G.M.#1), recently admitted to the hospital and a new member of an all-female group, has asked repeatedly (literally twenty times in the session) about going home: "Can't I go home? Please let me go home. Why can't I go home?" She interrupts continually with her refrain, and is listening to neither other group members nor the therapist in their efforts to help her examine the behavior that led to her hospitalization and was keeping her there (Farrelly & Brandsma, 1974, pp.152-153).

Towards the end of this group session, throughout which G.M.#1 had continued her message of "I don't need to be here" and "can't I go home", the therapist likened her behaviour to the 'Chinese water drop torture', explaining to group members in detail what this entailed, and then proceeded to say "blip" every time G.M.#1 asked versions of her "can't I go home?" question.

Other G.M.s begin taking up the therapist's "Blip" refrain.
G.M.#1 *(Hesitating; attempts to rephrase.)*: I believe I'm well now … can I go home?
G.M.s *(Laughing; some shaking their heads in disbelief; as a chorus)*: Blip!
G.M.#3 points out that G.M.#1 is not "consistent" enough yet to be discharged from the hospital.
G.M.#1 *(To G.M.#3; persisting.)*: I'm consistent in wanting to go home.
G.M.#4 *(Laughing.)*: *Per*sistent is the word.
G.M.#2 *(Interposing.)*: I disagree on that. She's not strong enough. She's sick. She's not ready to go home.
Therapist *(In a sing-song voice, wearily to G.M.#1.)*: Annie, do you think that if you just keep it up and keep it up and keep it up that the staff will get worn down and finally say: "O.K., damnit, we give up, go home"?
G.M.#1 *(Smiling.)*: Well, I don't know, I might try it, if it'd work.

(G.M.s and T. laugh, provoking G.M.#1 to laugh along with them.)

The next day in a large therapeutic community (T.C.) ward meeting, Annie opens the meeting with her deadeningly repetitious refrain. Several group therapy (G.T.) members who had been in the small group the previous day immediately respond as a chorus, "Blip!" and laugh. When other T.C. members look mystified, the G.T. members laughingly explain the comparison of Annie to the 'Chinese water drop torture'. Both T.C. and G.T. members begin humorously responding to Annie with "Blip" answers to her questions. Within the day she rapidly ceases asking

these and begins listening and responding in a sane, appropriate manner both in group therapy and on the ward (Farrelly & Brandsma, 1974, pp.153-154).

On the one hand this vignette describes an intervention that was unusual but also apparently effective, at least in modifying Annie's behaviour in the ward. On the other it does throw up questions about manipulation, power and focusing on a person's behaviour rather than their needs and concerns. Annie's persistence was annoying group members and presumably the group therapist and so the therapist came up with an innovative offbeat response he could influence group members to copy. There are implications here for my hypothesis about the relation between reason, absurdity and power.

Being playful 7: homework or, in this classification, 'homeplay'.

Therapists from all sorts of persuasions request clients do some homework between sessions. Cognitive therapists do so usually as a means for clients to
identify and externalise or objectify habitual negative cognitions, unrealistic expectations and demands, internal dialogues and self-attributes. Once the problem has been identified and put up for scrutiny there are various ways it can be converted into something comical. The following examples are described in their relevant sections in this chapter:

- creating a humorous stereotype or label for the problem;
- exaggerating the problem and turning it into a parody;
- writing a joke about a problem;
- drawing a cartoon of it;
- painting a comic mural of it;
- dialoguing equally ridiculous polarities of a problem, for example as a kind of Punch & Judy show and perhaps using props, or as a comic character and straight character dialogue;
- nonverbally playing problems, for example through mime, dance or facial grimaces;
- finding some music for a problem, such as a funeral march, war hero tune, a childrens' tune, wording it to a well-known song or tune;
- writing a problem or worry or unwanted behavioural pattern as a limerick, a poem, a riddle or a koan or turning it into a proverb, ironic affirmation or commandment.

As with serious therapy, clients will usually bring their completed homework to the following therapy session but, rather than being a topic of discussion, in humour therapy it will often be acted out, recited or sung.

Homework assignments are a common feature of paradoxical, strategic and brief therapies and these are discussed in this chapter's subsequent section on paradoxical and incongruity-based strategies.

PROVOCATIVE THERAPY – in which therapists are like court jesters, provoking and parodying, treating anything as 'fair game', "expressing the unutterable".

Examples in this category tend to be highly confronting and are mostly taken from, or developed from, the work of Frank Farrelly the creator of 'provocative therapy'. As I have already referred to many examples of Farrelly's therapy, this section will be kept relatively brief. In the following description by Farrelly of how he provokes clients, his approach appears to be absurd in the sense I have already discussed. Although he expresses faith in clients' ability to order disorderly experiences, in this case the therapist's disorderly behaviour, and from this see reason in his provocations, he nevertheless allows these provocations to be spontaneous, random and essentially meaningless.

> The provocative therapist approaches quickly those areas about which the client sends messages telling the therapist to avoid. (This has more picturesquely been termed by one client as "going for the jugular.") However, the therapist feels no necessary responsibility for theme development once there. The therapist's job is to stay with the client on a moment to moment basis in terms of affective level and avoidance behaviours. The client will bring order to this experience, develop the themes that he feels are important, and handle his own feelings (Farrelly & Brandsma, 1974, p. 59).

One of the exercises I give groups of absurd therapy trainees is a role-play in which one person talks about a real problem they are currently facing (client role) while a second person (therapist role) blurts out whatever comes into their mind without censoring it. These blurts can be verbal

or nonverbal and do not have to make sense or be in any way relevant to what the 'client' is talking about. Once the initial shock has worn off, 'clients' consistently go about making their own sense, finding their own meaning, from what they are experiencing in the exercise.

Farrelly's approach is at the more confrontational end of the absurd therapy spectrum and so inevitably leads to criticism from some therapists that it creates the risk of stepping beyond what they consider to be appropriate or ethical or therapeutic limits. I have heard this view put forward by a minority of participants at his workshops and also by university psychology students after watching videotapes of his sessions. Most often these critics accuse him of being sarcastic and ridiculing clients. Although she was not referring to Farrelly, this is in line with Buckman's opinion that some forms of humour are potentially destructive and therefore do not belong in therapy.

> There are five types of humour that are totally inappropriate for the therapeutic setting: ridicule, laughing at the client, cheap shots, put-downs, and sarcasm. These convey veiled anger and hostility for the client and can only be considered unethical (Buckman, 1994, p. xvi).

Farrelly acknowledges that ridicule is a powerful device that can be harmful if delivered aggressively but points to its "potency" as reason why it has a place in therapy if delivered with care. He gives numerous examples in his book of therapists ridiculing, 'putting down' and being sarcastic with clients, often with what he calls a "mock pomposity", designed to elicit self-assertive and reality-testing responses.

> Ridicule is the form of humor which raises the most professional eyebrows and questions, and perhaps rightly so, for if not qualified, it can be hurtful. In defense of this technique, however, we would like to point out its potency. All across the country today people are using this powerful aversive stimulus to modify the behaviour of others (families and playgrounds included). The late Saul Alinsky, the social organizer, has said, "Don't confuse laughter with the circus. Laughter and ridicule are the most devastating weapons that any organizer can ever use." Again it needs to be stressed that the provocative therapist ridicules not only the client's ideas and behaviours, but also his own role and "professional dignity" (Farrelly & Brandsma, 1974, p. 102).

He goes on to make a related point about sarcasm.

The dictionary talks of sarcasm with words like cutting, hostile, contemptuous, caustic and ironic. Although these adjectives could at times be applied to the provocative therapist's verbalizations, his "sarcasm" is almost invariably qualified by his facial expression, tone of voice, etc (1974, p.109).

Differences of opinion about the use of ridicule and sarcasm can arise from different interpretations of what these terms mean. As Farrelly points out above, dictionary definitions tend to portray them as inevitably harsh or malevolent in intent. For example, as well as "cutting", the Australian Macquarie dictionary refers to sarcasm as "sneering" and describes ridicule as designed to trigger laughter based on contempt. Farrelly's point is that these activities should not be defined as inherently and inevitably destructive but that the intent behind their use, and thereby the way in which they are delivered and received, can vary, in some cases "cutting" and in others enhancing.

As the superiority theory of humour points out, humour can be used as a form of aggression and 'one-upmanship' and this might always pose a potential risk in therapy. Obviously therapists working with humour, especially in a provocative manner as with Farrelly's approach, need to maintain a high level of awareness of their own motives and clients' needs and how they are responding to the therapist's interventions. It should be noted that these are important therapist characteristics in any approach to therapy. Farrelly makes this point in a provocative article co-written with a colleague at a large psychiatric hospital, in which they discuss the role of "punishment" with chronic schizophrenics.

There are those who fear that once the use of punishment is openly acknowledged and condoned, it might well serve as a vehicle for sadism. We sympathize with and share this concern; however, the essence of the problem is whether the therapist uses punishment solely for his own gratification or for the patient's welfare. Our position is simply that if a therapist is sadistic, he will be ingenious enough to find a vehicle for his sadism in any type of therapeutic approach even in benign nondirective therapies. Or, to put it differently, the beatific smile of the therapist does not guarantee that there are not fangs hidden behind it (Ludwig & Farrelly, 1967, p. 747).

This article was written at the same time Farrelly was developing provocative therapy, partly out of frustration with Rogerian client-centred therapy that was the established model at the

psychiatric institution where he worked. Farrelly describes how during the development of his approach he was regularly surprised by the positive responses he appeared to be eliciting from clients with whom he felt he was being "highly insulting and confronting" as summed up by one client's statement, "You're the most understanding person I've ever met. You really understand just how bad I am" (Farrelly & Brandsma, 1974, p. 28). Farrelly's approach does take the use of humour and paradox in therapy further than most others and would not suit all therapists, though Farrelly believes it can be used with all clients. Notwithstanding Farrelly's comments above, there does appear to be a greater risk in this approach to produce counter-therapeutic effects where therapists are not being vigilant about clients' responses to their provocations. This is probably a statement more concerned with Farrelly's trainees and followers than with him and in fairness to Farrelly, clients frequently describe their experience with him as positive and that they felt he understood and empathised with them.

There are several groups of interventions that can be included in this section, most but not all of which are found in Farrelly's work.

Being provocative 1: promoting a polarity response.

This is similar to intensifying the polarities of a dilemma described in the earlier section, *Creating Tension*, but, irrespective of whether tension is created in the client or not, it involves the deliberate provocation of the client to reject one of the polarities, usually the dysfunctional behaviour or thinking that has been creating the problems leading to seeking therapy. In the case of the *You're just not being reasonable!* family described in the previous chapter, the daughter's adoption of one set of behaviours was seen as a problem by her parents who then brought her, and themselves, into therapy. The daughter did not see her behaviour as problematic and she was antagonistic to the suggestion of the family having therapy essentially to address her behaviour. As the therapist's defence of the daughter's irresponsible rationalisations and behaviour became more and more bizarre and indefensible, she responded by increasingly adopting a more adult position.

Promoting or provoking a polarity response can be considered one of the more manipulative paradoxical techniques and as such has implications for potential power dynamics between therapists and clients. This is an important consideration in regards to the family in this case example as it was the parents who were defining the problem and insisting on therapy but it was their daughter who was the target for the therapist to provoke behavioural and, it appears, also some attitudinal change.

Being provocative 2: mirroring, negatively modelling, or mimicking aspects of clients' behaviour or cognitions that create problems.

This group of responses are mostly nonverbal, particularly posture, typical gestures and voice tone and tempo. They can involve matching or exaggerating the client's communicational, behavioural and cognitive styles, possibly leading the client to feelings of discomfort or embarrassment with how they are presenting behaviourally or cognitively. Two examples of this are Greenwald and myself exaggeratedly mirroring our almost identical clients wearing their tragedy outfits, heads in hands and sighing, described in the section on creating tension earlier in this chapter. The mimicking can be exaggeratedly theatrical. Similar activities would be for the therapist to role-play possible reactions of others, such as family members, to the client's behaviour or role-play caricatures or stereotypes that reflect aspects of the client's problem. One client responded to my mirroring her in this way with *"I know I do this but it seems so stupid when I see you doing it"*. An implied message from the therapist in these examples is "This is how I (and others) are perceiving you. How do you like it? Want to do something about it?"

Being provocative 3: satire and parody.

Satire, at least in a general sense as distinct from the Socratic use, is the use of words to project a meaning different to their literal meaning, and can be done as ridicule (keeping in mind the comments in the previous section) or just playfully. Therapists can also use dramatic irony to highlight incongruities between clients' meanings and situations presented to therapy and their

intended meanings and desired situations. Parody is essentially a dramatic and humorous means of representing (re-presenting) material presented by clients to therapy.

Being provocative 4: bantering with clients.

Bantering is being playfully teasing, something friends do with each other a lot, which differentiates it from other irritating or hostile forms of teasing. Referring to examples of the clinical use of banter with obsessive compulsive disorder, Buckman (1994) states:

> The therapist as a psychological humorist engages the obsessional client in banter and then assists the client in gaining insight from it…… … Bantering is viewed by Sperling (1953) as a socialized evolution of early childhood teasing, which polarizes incongruencies such as pleasure-pain, hostility-friendliness, and seriousness-playfulness. Through this humorous incongruity of teasing, the client can gain an appreciation of himself (pp. 14-15).

Being provocative 5: therapist advocates unreasonable blame.

Blame of self or others is a common presentation in therapy sessions. A reason-based approach to therapy will usually attempt to help clients identify who or what they are blaming, see the unreasonableness and unhelpfulness of this, and work out more constructive ways to ascribe responsibility. Provocatively absurd therapists have a range of options available, all of which involve insisting on blaming somebody or something to the point of indefensibility. They take the client's target of blame as their starting point, and then either exaggerate it or emphasise how everything else is to blame instead. Everything is blameworthy. Yourself, your parents, your partner, your partner's parents, your kids, your boss, the taxman, school, your unconscious mind, drugs, God, nothing and nobody is taboo in this absurd orgy of blaming that is really a parody of the client's unreasonable habitual process.

Being provocative 6: therapist interrupting or talking over clients.

Farrelly frequently interrupts clients while they are talking, thereby derailing their train of thought, often with surprising and unusual brief comments and questions. This is most useful when clients are simply repeating habitual series of thoughts, something people do commonly,

thinking or talking themselves into a virtually self-hypnotic state. Short, sharp, attention-grabbing interruptions act as pattern breakers putting the person temporarily off-balance.

Two other examples are to run a verbal or nonverbal commentary while clients are themselves speaking or to maintain a discussion with members of a family in family therapy about one member of the family as though the person being discussed is not present. In the case of the *You're just not being reasonable!* family referred to earlier, the therapist spent prolonged periods whispering (loudly enough to be audible to the parents) in the adolescent's ear about how old-fashioned, non-understanding and unreasonable her parents were being not to allow her to stuff her dirty clothes under the bed or to stay out all night with boys and drugs.

The interventions in this section would usually be introduced either to interrupt clients' habitual processes, or as a meta-commentary on clients' behaviours, or both. They are usually verbal interruptions but can also be nonverbal. A couple came to see me for assistance sorting through numerous disagreements they were having. Within only a few minutes into their first session they had launched into a mutual blaming battle over a multiplicity of trivial behaviours and habits each disliked about the other, such as leaving pegs on the clothes line and throwing out newspapers without checking if the other had read them all. I realised their expectations were that I would act as referee but both were so absorbed in the battle they became oblivious of my presence. I managed to attract their attention a couple of times and reflect to them my concerns about their behaviour and expectations but they resumed full-scale battle each time within minutes. After twenty minutes of this I 'gave up' trying for a ceasefire, deciding instead to spend the rest of the session playing with an array of theatrical nonverbal activities while they fought on apparently unaware of my behaviour. My nonverbal meta-commentary included feigning reactions such as horror, awe, disgust and fear, exaggerating "I told you so" body postures and facial expressions, waving my finger and mouthing "tut-tut", frowning, grimacing, miming vomiting, nonverbally guffawing, and many more silent responses to their interminable self-absorbing barrages of blame. Suddenly, and together, they became aware of me, stopped mid-sentences and looked at me for the first time in twenty or more minutes. I immediately requested payment of my fee and while sniffing the notes told them how "it warms me to the cockles of my heart that people like you two are prepared to pay me hard-earned money like

this to witness performances like that" and that we were scheduled to meet the same time the following week when they were welcome to do it all over again. I could not be sure they would return but they did and we had several sessions together. They never lost awareness of my presence in a session again and by recognising the self-perpetuating nature of their fighting they were able to develop more useful ways to deal with conflict. At our last meeting the three of us fell about in hysterical laughter with a brief re-enactment of that first session.

Being provocative 7: accepting or matching clients' delusions.

At first sight it would seem that the reasonable thing to do with delusions would be to help the person see through them and realise they are not real. It would therefore seem absurd to agree, or at least pretend to agree, with a person's delusions and even more so to try matching the other person's delusions by pretending to have delusions of one's own, such as in the following vignette.

A lady with a fixed somatic delusion about having breast cancer was referred by a surgeon that she had been pestering for two years. In the initial interview, she began asking a lot of questions, implying that the psychiatrist just might be fake. In the middle of the interview, the psychiatrist suddenly flipped it and became suspicious that she was an investigator from the State Board of Health. He had heard that such investigators were going around disguised as patients checking out psychiatrists' competence. He became suspicious that the little pin on her blouse was a microphone. She told him that he could examine it, but he feared that was only a trick to get him to touch her breasts so that she could report him for sexual abuse. The exchange went on for a few minutes before the schizophrenic patient said, "Listen, Doctor, this is no joke. Now stop this silliness" (Keith & Whitaker, 1981, p. 251).

The irony is that attempting to demolish a person's delusions through reason often turns out to be an unreasonable and ineffective strategy whereas accepting the delusions can be the first stage of helping the person reject them. Something that from one perspective appears rational, from another can be seen to be absurd. When people are challenged about their ideas, constructs, beliefs, they are more likely to jump to their defence, at least initially or until the evidence against them becomes overwhelming, and even then there is no guarantee of them changing. Milton Erickson emphasised the importance of first walking with clients and their symptoms, which he called "pacing the client", before trying to influence change. Opposition to

clients is more likely to lead to them becoming resistant to the therapist's influence. "Pacing" clients creates a relationship through which they can be open to the possibility of change. Erickson described an early case in his career where this process can be seen.

A patient in Worcester State Hospital in Massachusetts demanded he be locked in his room, and he spent his time anxiously and fearfully winding string around the bars of the window of the room. He knew his enemies were going to come in and kill him, and the window was the only opening. The thin iron bars seemed to him to be too weak so he reinforced them with string.

I went into the room and helped him reinforce the iron bars with string. In doing so, I discovered that there were cracks in the floor and suggested that those cracks ought to be stuffed with newspaper so that there was no possibility (of his enemies getting him), and then I discovered cracks around the door that should be stuffed with newspaper. Gradually I got him to realize that the room was only one of a number of rooms on the ward, and to accept the attendants as part of his defense against his enemies; and then the Board of Mental Health of Massachusetts as part, and then the police system; and the governor. And then I spread it to adjoining states and finally I made the United States a part of his defense system, which enabled him to dispense with the locked door because he had so many other lines of defense.

I didn't try to correct his psychotic idea that his enemies would kill him. I merely pointed out that he had an endless number of defenders. The result was: the patient was able to accept ground privileges and wander around the ground safely. He ceased his frantic endeavors (Zeig, 1985, pp. 91-92).

PARADOXICAL AND INCONGRUITY-BASED STRATEGIES

Most of the approaches in this category are taken from a group of therapy models that grew out of the work of Milton Erickson and can be generally referred to as brief strategic therapies. Although mostly paradoxical, these interventions are often used by therapists specifically to bring about identified intended outcomes and, as discussed earlier, might thereby fall outside a restricted definition of absurdity.

This is a selection of paradoxical interventions and is not meant to be a comprehensive compilation. As they have been described in detail in the paradoxical, strategic and brief therapy literature my comments are succinct.

Being paradoxical 1: addressing a problem without directly taking it on.

A linear approach to reducing a problem, such as poor health or excessive smoking or alcohol use, would focus on directly trying to change the problem, such as by developing an exercise regimen, or trying to smoke and drink less. Taking problems like these head on by trying to change behaviours within the same context they have flourished in, is difficult indeed, and more often than not unsuccessful. The following case example was described by Milton Erickson and recorded by Sydney Rosen in his compilation of some of the stories used by Erickson as teaching tales for clients and supervisees. It demonstrates how problematic behaviours can be changed by focusing on the context within which they occur and are maintained, and promoting a new, positive behaviour, rather than simply slogging away directly at the problem behaviour itself.

A medically retired policeman told me, "I have emphysema, high blood pressure, and, as you can see, I am grossly overweight. I drink too much. I eat too much. I want a job but my emphysema and high blood pressure prevent that. I would like to cut down on my smoking. I'd like to get rid of it. I'd like to quit drinking about a fifth of whiskey a day and I'd like to eat sensibly."

I said, "Are you married?"

He said, "No, I'm a bachelor. I usually do my own cooking, but there's a handy little restaurant around the corner that I often visit."

"So, there's a handy little restaurant around the corner where you can dine. Where do you buy your cigarettes?"

He bought two cartons at a time. I said, "In other words, you buy cigarettes not for today but for the future. Now, since you do most of your own cooking, where do you shop?"

"Fortunately there is a little grocery right around the corner. That's where I get my groceries and my cigarettes."

"Where do you get your liquor?"

" Fortunately there is a nice liquor store right next to that grocery."

"So, you have a handy restaurant right around the corner, a handy grocery right around the corner, and a handy liquor store right around the corner. And you want to jog and you know you can't jog. Now, your problem is very simple. You want to jog but you can't. But you can walk. All right, buy your cigarettes one pack at a time. Walk across town to buy your pack. That will start to get you in shape. As for your groceries, don't shop at the handy grocery right around the corner. Go to a grocery a half mile or a mile away and buy just enough for each meal. That means three nice walks a day. As for your liquor, you can drink all you want to. Take your first drink at a bar at least a mile away. If you want a second drink, find another bar at least a mile away. If you want a third drink, find another bar a mile away."

He looked at me with the greatest of anger. He swore at me. He left raging.

About a month later a new patient came in. He said, "A retired policeman referred me to you. He said you are the one psychiatrist who knows what he is doing."

The policeman couldn't buy a carton of cigarettes after that! And he knew that walking to the grocery was a conscious act. He had control of it. Now, I didn't take food away from him. I didn't take tobacco away, I didn't take liquor away. I gave him the opportunity to walk Rosen, 1982, pp. 149-150).

Rosen comments that Erickson approached this client from the perspective that he was used to following orders and so expected him to follow these, whereas his means of providing the tasks to other clients may be different. The point is to enter each client's contexts and personalise both the intervention and its mode of delivery.

Being paradoxical 2: prescribing the problem or the symptom.

Variations of this approach constitute the most common form of therapeutic paradoxical intervention. Prescriptions are most commonly given as activities to perform outside the therapy session, in other words as a form of homework, though they be initiated during a session. They may involve exaggerating the problem, or only performing the activity at specific times or in a specific place, or attaching incongruous elements to the activity. I have used all three of these with bulimic clients, such as having the person binge twice as much even when they do not

want to, restricting the binge-purge to an inconvenient time or only to be done in the bathroom, or wearing their best party dress and make-up for the occasion. Another example of this approach is the compulsive light switcher described earlier in 'creating tension 4'. These are forms of pattern interruption in which the person's entrenched pattern of behaviour or thinking is interfered with by the intrusion of something new

Although most symptom prescription interventions have come about through the influence of Milton Erickson, examples can also be found in various schools of therapy, some predating Erickson, such as Alfred Adler, behaviourism, gestalt therapy and Frankl's logotherapy in which the practice is called "paradoxical intention" and usually involves humour. Adler, Frankl and behaviourists were using their versions of symptom prescription in the 1920s.

Being paradoxical 3: 'ordeal therapy', providing worse alternatives or accompanying behaviours.

This involves attaching an undesirable task to the problem behaviour to provide motivation to cease the problem behaviour. Whenever the person performs the problem behaviour, she also has to perform the attached task. The task is at least as undesirable and distressing as the problem. Examples of this approach can be found in Haley's book *Ordeal Therapy* (1984) and his keynote address to the Second International Congress on Ericksonian Approaches to Hypnosis and Psychotherapy (Haley, 1985, p. 9). Haley states that, to have therapeutic value the ordeal should:

- be "appropriate to the problem";
- "cause distress equal to or greater than that caused by the symptom";
- be "good for the person", such as involving "exercise, improving the mind, eating a healthy diet, and other self-improvement activities";
- "be something the person *can* do and something the person cannot legitimately object to";
- and not be harmful to the client or any other person.

Being paradoxical 4: restraining, obstructing or forbidding change.

This approach is paradoxical in face of the assumption that therapists are supposed to be assisting clients progress towards positive change, not provide obstacles to it or tell them stop getting over their problem. It is a form of therapeutic double-bind in which the therapist is saying "if you want to change, give up trying to, stay as you are". It is mostly used with clients who appear to be changing too quickly and might sabotage the process out of fear or creation of instability in their relationships and with clients who might be trying to change to please the therapist, potentially creating a dependency relationship. It can also be a means to promote a response in the client to defy the therapist's instruction by adopting the new behaviour, as was the case with the couple seeking help with their sexual relationship described early in the previous chapter.

Being paradoxical 5: predicting or prescribing a relapse.

In some respects this is a version of the previous approach as it appears to be hindering change. There are various ways it can be used and it can have therapeutic value both when there is a relapse and when there is not. If there is a relapse, new creative ways to deal with it can be developed. The fact that it was predicted and framed as not out of the ordinary often renders it less anxiety-provoking or disappointing for the client. If there is no relapse, clients usually experience a sense of accomplishment and control. It can also be a mild form of challenging the client to maintain their improvement to prove the therapist wrong, such as my bet with the recovering bulimic client in 'creating tension 5'. Therapists can perform these activities with an air of seriousness, as is often the case in strategic approaches to therapy, or, as is my preference, with humorous provocation and playfulness.

Being paradoxical 6: reframing and relabelling.

Reframing a problem means redefining the meaning or role it has been given in the person's, or family's, life. It often means replacing a negative label that implies dysfunction or pathology with a positive focus on how people are attempting to adapt to or cope with situations. It also

shifts the focus from being out of control to attempting to exercise control. For example, a female teenage bulimic client changed her view of, and way of dealing with, her behaviour when I reframed it as her attempt to stop her parents' fighting by uniting them in the cause of rescuing her from the tyranny of bulimia. I advised her to stop being an amateur marriage counsellor and get on with being a mixed up teenager. I told her I was better trained than her and could do a better job with her parents if she would let me.

ADDRESSING PROBLEMS INDIRECTLY AND IMPLICITLY

Therapists interested in indirect approaches to therapy should always be on the lookout for good stories, anecdotes and images, including from movie and television comedies, funny books, stand-up comedians and cartoons, and to work out ways to use or adapt these with clients. This is research that is fun and energising to do. Most of these sources of humorous material are metaphors about everyday life with a comic twist and as such are easy to reapply to all sorts of life experiences and situations. As Greenwald points out, psychology and psychotherapy training can be very theory-bound but working directly with a person's problems is real and immediate.

> The trouble is, when you learn psychotherapy, the one thing they don't tell you is what to do when you see a patient. You learn the theory, but what do you do? I found out by going to the movies. In the movies I discovered that the way you do therapy is to be a dedicated co-sufferer. The patient comes in and he suffers and you sit there and suffer with him (Greenwald, 1985, p. 237).

As Frank Farrelly once said to me, "life has a nasty habit of slopping all over our paradigms" (personal communication).

Being indirect 1: comedy television and movies.

Sometimes I simply request a client to watch comedy programmes or movies, either as a general 'pick-me-up' or in some cases as a specific metaphor for their situation. An example of the latter

is a British movie *Truly, Madly, Deeply* in which the deceased husband of a woman stuck in chronic grief returns to help her resolve her grief and re-establish a life for herself without him. The means he employs to do this are often hilarious though still with a sense of the seriousness of his task and the tragedy of her loss. Two of my favourite television comedy series depicting the absurdity of life, that seem to work well with clients, are *Fawlty Towers* and *Mr. Bean* both of which leave people cringing while laughing at human folly, not only of the characters but of all of us.

Being indirect 2: vivid imagery.

Vivid, emotionally stimulating imagery can be used as a specific means to elicit strong reactions in clients, as with the *Gore Galore* case described earlier in this chapter. As mentioned in the previous chapter, it can also serve as a means to anchor certain themes in clients' memories as imagery tends to be more memorable than verbal labels on their own. Putting vivid imagery and bizarre labels often makes the theme even more memorable. Several anchoring labels are provided later in this chapter.

In a demonstration session at one of Frank Farrelly's provocative therapy training workshops a client explained to Farrelly how he was sick of "being pissed on all the time" but could not seem to be able to stop it occurring. At this point, a reasonable therapist would probably introduce the client to some cognitive behavioural assertiveness strategies. Farrelly did not mention assertiveness but developed a multi-sensorial metaphor of the client being a helpless little deodorant cake lying defenceless in the urinal trough of a men's public toilet. Farrelly looked upwards, covered his face with his arms and cried out "Oh no, here comes another lot!" and ended the session by naming the client *Mr. Urinal Cake*. Farrelly later explained to me that he hoped the imagery would return to the client every time he began to feel he was "being pissed on" by someone to create a comprehensive, not simply cognitive, reaction to prompt him to "get out of the downpour or stop the prick before he starts". "He needs to have the full experience, not just think about being assertive. I hope he can taste it – that'll motivate him to stop it happening."

Being indirect 3: cartoons, funny drawings, caricatures.

This can involve clients and therapists bringing into sessions cartoons that demonstrate some aspect of the problem or, even better, clients drawing their own cartoon, painting a comic mural or creating a comic collage of the problem, or of some aspect of their own behaviour, their mind or their life. This can also be a group activity, such as a group photo collage or group mural, and can be used in organisational/team building sessions. Caricature can be a powerful device through which some peculiarity of a person or situation becomes highlighted in an amusing way. In therapy clients draw caricatures about themselves and then play with the comical theme in the session.

Being indirect 4: music.

Clients might be asked to find a tune that can be used to parody something about themselves. Popular tunes have been the funeral march, war hero themes, and tunes from comedy programs such as *Fawlty Towers*. The *Teletubbies* tune did well for a while as a way clients would poke fun at how silly and pointless they realised they were being. On a number of occasions I have sung together with depressed, self-defeating, pessimistic clients, the song *Always Look on the Bright Side of Life* from *Monty Python's Life of Brian*. I also used this as a group exercise after which the group participants, most of whom had attempted suicide at least once, adopted it as their shared anthem and promised to sing it if they found themselves considering suicide as an option. I was going to place this song as an appendix but finally decided to include it here because the words should be read to gain a sense of what effect the song can have on depressed and suicidal people when sung in the spirit of jovial healthy self-ridicule, especially in chorus.

ALWAYS LOOK ON THE BRIGHT SIDE OF LIFE

From *Monty Python's Life of Brian*

Some things in life are bad,
they can really make you mad.
Other things just make you swear and curse.
When you're chewing on life's gristle,

don't grumble, give a whistle,
and this'll help things turn out for the best

Chorus:
And…..
Always look on the bright side of life *(whistle)*
Always look on the bright side of life *(whistle)*

If life seems jolly rotten
there's something you've forgotten,
and that's to laugh and smile and dance and sing.
When you're feeling in the dumps,
don't be silly chumps,
just purse your lips and whistle
that's the thing.

Chorus

For life is quite absurd
And death's the final word.
You must always face the curtain with a bow.
Forget about your sin,
give the audience a grin.
Enjoy it, its your last chance anyhow.

So always look on the bright side of death
just before you draw your terminal breath.
'Cause life is one great hit when you look at it.
Life's a laugh and death's a joke, it's true.
You'll see its all a show.
Keep 'em laughing as you go.
Just remember that the last laugh is on you.

Chorus

Come on guys, cheer up,
worse things happen at sea you know.

Chorus

I mean, what have you got to lose?
You know, you come from nothing, you're going back to nothing.
What have you lost? Nothing!

Chorus

A more creative option is to compose a humorous song about the problem, usually by putting the words to an existing well-known tune. Albert Ellis had a collection of such songs though I prefer clients to compose their own and have frequently been impressed by how well people do this. At one of my humour workshops a participant announced on the second day that on the previous evening she had composed such a song about a considerable, and very personal, difficulty she had been struggling with for much of her life and, though anxious about doing so, she had decided to sing this in front of everyone at the workshop as her first step in finally releasing herself from the problem. She had even composed a satirical chorus, representing "all self-denigrating voices in my own head", that we had to sing to her during the performance.

Ellis converted numerous well-known songs into what he called "rational, humorous songs" written to help people poke fun at their irrational thinking and behaviour (Ellis, 1987). His songs included titles such as *Whine, Whine, Whine*, *I Am Just a Fucking Baby!*, and *Oh, How I Hate to Get Up and Get Going!* which is sung to the tune of Irving Berlin's song *Oh, How I Hate to Get Up in the Morning*.

Oh, how I hate to get up and get going!
Oh, how I love to procrastinate!
For the hardest thing I know
Is to hear the whistle blow,
"You gotta get on, you gotta get on,
You gotta get on and stop slowing!"

Someday, I promise that I will get going - -
Someday, but never, of course, today!
I think I'll still procrastinate
And always get my ass in late,
And piss the rest of my life away!

Rationality necessitates censoring and exclusion of the irrational. As rational therapists would be attempting to apply reason to their analysis of clients' problems and consideration of possible solutions, spontaneously arising mental images, memories and sensory experiences would not normally be considered as relevant or helpful. Indeed they might be seen as an irrelevant interference to the serious task at hand. Absurd therapists allow themselves to throw into the session anything that comes up for them, irrespective of whether or not it seems connected to the content of the session at the time. It takes a radical leap of faith for most therapists to allow themselves to do this as it flies in the face of most psychology, counselling and therapy training.

I find tunes, lines from songs, poems or plays, and visual images pop into my mind frequently during therapy sessions. I have identified that the more I am absorbed in what a client is saying, the more of these mental images arise for me, and that blurting them out more often than not is made meaningful by the client. Greenwald describes the same process.

Often as I listen to patients talking, lines from plays, song titles or movie titles spring unbidden into my mind. Instead of keeping them to myself, I now frequently share such associations and often find them helpful. …… Often I have had impulses to react in what would seem like an irrational manner to something that was being said. I found that if I permitted myself to play out the impulse, it led to a considerable reduction in anxiety and that the patient found the experience helpful (1967, p. 44).

The impulsive expression of musical items popping into consciousness can be considered an absurd thing for therapists to do, but it can have therapeutic value. In my training workshops I call this exercise 'blurt therapy' as the participant in the therapist role is told to blurt out to the participant they are working with in a client role, who is working on a real problem of their own not role-playing one of their clients, whatever pops into their mind however irrelevant it might

initially appear to them to be. In most cases, the 'client' makes some sense of, or projects meaning onto, the spontaneous and apparently irrelevant blurt.

Being indirect 5: funny poems, limericks.

Here are a couple of limericks written by ex-clients of mine.

There was a young woman with bulimia
Who refused to let anyone get near her
Instead she would binge
So she could stay on the fringe
And she just got weirder and weirder and weirder

There was a cranky old bastard who was a dud
He pissed everyone off 'cause he could
Then came a day when he suddenly thought
I'm all alone and its my own fucking fault
So he got smart and started being nice, 'cause he should.

This second limerick was written by a company managing director. Some time after writing this he reported enjoying work more and getting on with his staff better. He also reported getting his management team to bring limericks to meetings as a way of "lightening the damn things up a little".

Being indirect 6: riddles, puns and one-liners.

Riddles can be intended to have relevance as metaphors or can simply be a way of promoting rapport, defusing the session for a moment or as, in the words of Keith and Whitaker (1981), "a way of enjoying our own stupidity so that our interventions do not appear to emanate from us as paragons of mental health" (p. 250).

The following punning was circulated a few years ago as a general email by Jeff Zeig, Director of the Milton H. Erickson Foundation. These are pretend quotes from a, presumably not real, book called *My Karma Ran Over My Dogma* by the, presumably not real, author Swami Beyondananda.

Be a Fundamentalist – make sure the fun always comes before the mental. Realise that life is a situation comedy that will never be cancelled. A laugh track has been provided, and the reason why we are put in the material world is to get more material. Have a good laugh at least twice a day, and that will ensure regular hilarity.

It is true. As we go through life thinking heavy thoughts, thought particles tend to get caught between the ears, causing a condition called truth decay. So be sure to use mental floss twice a day. And when you are tempted to practice tantrum yoga, remember what we teach in Swami's Absurdiveness Training class: Don't get even, get odd.

One-liners can be take-offs of koans, for example the well-known koan "what is the sound of one hand clapping" can become "what is the sound of one knee knocking?" or "…of one tooth chattering?" or "… of one brain cell straining?".
Also some comedians and comic writers are good sources of one-liners, such as the Victor Borge and Steven Wright quotes mentioned earlier. Steven Wright is a very dry stand-up comedian who I find currently to be the best source of one-liners and ironic proverbs for use in therapy. A few more of these are in the next section.

Being indirect 7: ironic proverbs.

These humorous, ironic and self-lampooning proverbs have been taken from multiple sources, mostly by e-mail or generated in the author's therapy sessions and training workshops.

- Try not to be as judgemental as all those censorious, self-righteous people around you.
- Why continue with quiet self-pity when you can move up to incessant nagging?
- A good scapegoat is nearly as welcome as a solution to the problem.
- The complete lack of evidence is the surest sign that the conspiracy is working.
- Avoid getting lost in thought if its unfamiliar territory.
- The things that come to those who wait may be the things left by those who got there first.
- Don't take life too seriously, you're not getting out alive anyway.

In their discussion of Adlerian therapeutic use of humour, Mosak and Maniacci (1993, pp. 9-10) call these "twisted adages". Some of their examples are:

- The best offence is a good pretence.
- If you can't be big, be-little.
- If you can keep your head while all about you are losing theirs, you don't understand the situation.

Finally, some from Steven Wright.

- 42.7 percent of all statistics are made up on the spot.
- I feel like I'm diagonally parked in a parallel universe.
- Remember, half the people you know are below average.
- He who laughs last thinks slowest.
- Depression is merely anger without enthusiasm.
- A clear conscience is usually the sign of a bad memory.
- Plan to be spontaneous tomorrow.
- Always try to be modest, and be proud of it!
- If you think nobody cares, try missing a couple of payments.
- If everything seems to be going well, you have obviously overlooked something.
- When everything is coming your way, you're in the wrong lane.
- Hard work pays off in the future. Laziness pays off now.
- Inside every older person is a younger person wondering what the hell happened?

Being indirect 8: negative affirmations ('naffirmations').

Absurd affirmations that can be used in therapy reflect and parody the negative messages people persistently haunt themselves with. Given this, I use the term 'naffirmations' when introducing them to clients.

As with the proverbs, the following naffirmations have been acquired through e-mails or developed during the author's therapy sessions or professional training workshops.

- I assume full responsibility for my actions, except all the ones that are someone else's fault.
- I no longer need to punish, deceive or compromise myself. Unless, of course, I want to stay employed.
- My intuition nearly makes up for my lack of good judgement.
- I honour my personality flaws, for without them I would have no personality at all.
- All of me is beautiful and valuable, even the ugly, stupid and disgusting bits.
- I am at one with my duality.
- I can come to terms with my limitations, after all they are not my fault.
- I am willing to make the mistakes if someone else is willing to learn from them.
- I started out with nothing and I am managing to hang on to most of it.
- As I let go of my shoulds and feelings of guilt, I can get in touch with my inner sociopath.
- I have the power to channel my imagination into ever-soaring levels of suspicion and paranoia.
- I can transform any negative thought into an even worse reality.
- I can hold my breath until he/she/everyone else turns blue (in other words does what I want).

Here are a couple of quirky naffirmations developed by participants in humour therapy workshops that do not initially look right but seem puzzling and are somehow enhanced by contradiction or wording reversed to how it would be normally.

- I move towards peace and love like a slug on steroids.
- I sit comfortably with myself as a teenager on a zit. (The group that came up with this originally had "zit on a teenager" but reversed it for impact.)

Postcards and books containing naffirmations are also becoming popular and can be used in therapy, for example the ones printed by Brilliant Enterprises in California, such as:

- All I want is a little more than I'll ever get.
- I am unconditionally guaranteed to be full of defects.
- Wait a minute, come back – there's a part of me you haven't stepped on yet.

Being indirect 9: 'demandments' and 'musturbations'.

THE TWELVE DEMANDMENTS (adapted from Albert Ellis by Walter O'Connell, in Corsini, 1981, p. 557, *italics in original*.):

1. I MUST be loved and approved of by everyone for everything at all times.
2. I MUST be thoroughly competent, adequate and achieving in *all* possible respects.
3. Some people *are* bad, wicked or vile and MUST be punished.
4. Things MUST go the way I very much want them to or it would be *awful, catastrophic* or *terrible!* (awfulizing …… terriblizing).
5. Unhappiness is externally caused so I MUST control things and others.
6. One MUST remain upset or worried if faced with a dangerous or fearsome reality.
7. I MUST avoid responsibilities and difficulties rather than face them.
8. I MUST have a *right* to be dependent and people MUST be happy to take care of me.
9. My early childhood experiences MUST continue to *control* me and determine my emotions and behavior!
10. I MUST become upset over my and other people's problems or behavior.
11. There MUST be *one* right, precise and *perfect* solution and it would be *terrible* or *catastrophic* if this perfect solution is not found (catastrophizing).
12. The world MUST be fair and justice (or mercy) MUST triumph.

Being indirect 10: anchoring labels.

These are humorous names given to clients, couples, families and even groups (such as my 'duffers' group of bulimics mentioned earlier) to encapsulate and make memorable an aspect of their problematic behaviour and, as mentioned earlier, are more emotionally stimulating and memorable when associated with vivid imagery. They can also be titles given to individual therapy sessions, such as Farrelly's *Weird Left Tit Interview* described in the previous chapter. This practice stems back to Adler's use of what he called "handles", brief titles that conjure up associated imagery reflecting the principle that 'one picture is worth a thousand words'. Examples of anchoring labels given to individuals are:

- Farrelly gave the title *Mrs. Absolute Zero* because having had five orgasms in over 2200 acts of sexual intercourse put her "beyond frigidity'.
- The client describing himself as being sick of people "pissing" on him became *Mr. Urinal Cake.*
- *Ageing Bo Peep* was a middle-aged woman who kept taking care of dependent men.
- *Ready – Fire – Aim* depicts clients who tend to barge in prematurely with comments or actions.
- *Ready, Steady, Run Backwards*. The therapist jumps up and demonstrates this while adding that this is being done in a race where everyone else is running forward.

Labels that I have used with couples and families include:

- *The Ventriloquist and his (her) Dummy.*
- *Mr. & Mrs. MSG/Saccharine.*
- *Sir Lance-a-lot and the Pathetic Damsel (aka Poor Poopsie).*
- *The M.A.D. Family* which stands for Mutually Assured Destruction, the term used during the Cold War to describe the U.S. and U.S.S.R. policies on nuclear war.
- *The Buddha and The Cyclone* were a married couple who had developed a dysfunctional reciprocity in which she would get angrier and he would withdraw. The wilder she became, the more he would drift off into his meditative avoidant posture and facial expression. The

more he did this, the more cyclonic she became. I pointed out that it did not matter who started because their reactions had now become automatic at the first sign of conflict.

Being indirect 11: acronyms.

Acronyms can be used as anchoring labels as described above, such as the mutually assured destruction (M.A.D,) couple or as a means of creating a condensed (and thereby memorable) description of a particular behavioural style. For example Walter O'Connell, the developer of "natural high therapy", an approach strongly based on the therapeutic use of humour, uses the acronym O.A.F. He explains that to OAF is to **O**wn a problem, in the sense of becoming focused, perhaps obsessed with it; see it as **A**wful as possible; and then turn the whole thing into a personal battle, or **F**ight, thereby pumping energy into the problem and ensuring its continuation.

The more you attempt to resist and control pain, anxiety, depression, boredom etc., the more they become a part of your potential for useless power ploys. When we OAF a feeling, thought or perception, we OWN, AWFULIZE, and FIGHT those happenings thereby solidifying them in our attention (or 'mind'). The humorist, on the other hand, watches, records in awareness, shares, and even celebrates his or her constrictions; but there is little OAFing of any behaviors. Reactions are seen to be like autumn leaves on a stream. They are perceived but not owned, awfulized and fought against. They flow on, part of a passing stream of consciousness (O'Connell, 1981b, p. 41).

Being indirect 12: humorous diagnoses and treatments.

Diagnoses:

- cirrhosis of the attitude
- repetitive doormat injury
- repetitive strained relationship injury
- excuse overuse syndrome
- excessive musturbation
- misplaced affection disorder (MAD, as in you're mad to still be with him)

Treatments:

- attitude transplant
- body image transplant
- triple guilt bypass
- radical mustectomy (for the treatment of musturbation)
- bullshit replacement therapy
- shouldoscopy

Treatments can also be paradoxical, proposing to make the client do more of the problematic behaviour or thinking.

- pessimism enhancement program (PEP)
- optimism and hopefulness nullification operation (OH NO)

Being indirect 13: storytelling and analogy.

This group refers to therapists telling metaphors, myths, fables, fairy tales, parables, anecdotes, analogies, quotes, tales about other clients' experiences, and therapists' self-disclosure. For convenience, all of these forms of communication can be grouped under the general title of 'metaphor' as defined in the Macquarie Dictionary, Second Edition: "a figure of speech in which a term or phrase is applied to something to which it is not literally applicable, in order to suggest a resemblance". A metaphor is a verbal representation of thing/event/experience (#1) through the description of a different thing/event/experience (#2) that may assist the listener to discover something new about #1.

It can be reasonably assumed that metaphor has been a vehicle for novel experience, new insights and behavioural change since before recorded history in forms of parable, teaching tales, fables, myths, fairy tales, poetry, and analogy. All forms of modern psychotherapy have metaphor of some sort in their practice though type, extent of use and degree of similarity between metaphor and that which is being represented vary considerably. In one sense all therapy is metaphorical in that the client and therapist are representing experience through

language and using that language to construct their experiences and meanings. In this same sense it could be said that all communication is then metaphorical. The meaning of metaphor used in this thesis is the deliberate application of one description by a person to a different experience of another person that can influence some sort of change in the second person. Some forms of modern psychotherapy include metaphor in this sense as components of their practice. The psychotherapist most known for use of metaphor is unquestionably Milton Erickson and comprehensive descriptions and compilations of his metaphors can be found in Zeig (1980, 1985) and Rosen (1982).

There are many useful sources of stories that can be used as metaphor in therapy including modern compilations of teaching tales from various spiritual and cultural traditions such as Sufi (*The Subtleties and Exploits of the Inimitable Mulla Nasrudin*, Idries Shah, 1983); a compilation of tales from different religions put together by a Catholic priest (*The Song of the Bird,* Anthony de Mello, 1984), Sanskrit fables (*Kalila and Dimna; Selected Fables of Bidpai*, retold by Ramsay Wood, 1982) and Zen Buddhism (*Zen Flesh, Zen Bones*, edited by Paul Reps and Nyogen Senzaki, 1994).

Some specific comments are appropriate here about telling clients stories about other clients' experiences, and therapists relating stories about their own experiences, self-disclosure, as forms of metaphor.

Telling other clients' stories.

Telling clients tales of other peoples' similar experiences and ways they dealt with their problems can be a particularly helpful exercise. This can be likened to the sharing in group therapy of personal experiences and both successful and unsuccessful attempts to resolve issues. This is not really an example of absurdity in that there would normally be a rationale for telling that particular story to that particular client at that time. In light of this, therapists would have a sense of the relevance of the story to their clients. Obviously, other clients' stories should also be told in a way that does not reveal any personal information about the person, thereby not compromising confidentiality.

I have often passed on to clients with permanent physical injury a personal story I heard in a Margaret Throsby interview with John Courtis, on 26th July 2001, in her weekday morning ABC Radio National program. John was born with no bones below his pelvis and, as he said in the interview, was the size of a can of soft drink at birth and is now as an adult still only 2′ 6″. John's story is about responding to life-long tragedy with courage, positive attitude and humour. There is one part of his story, as relayed in the radio interview, that I particularly like to tell clients. It is not an accurate rendering of his words as, not having a transcript, I am only recalling from memory. John described his wife and him as a perfect match as he is 2′ 6″ and she is 6′ 2″. They had intended having children but not long into their relationship he was diagnosed with cancer in one of his testicles. The surgeon advised that it would be essential to remove that testicle but also recommended the other's removal, leaving John with a few days to make a decision on this. Margaret Throsby commented on his strong sense of humour, very evident throughout the interview, which was all the more notable given the difficulties he had faced throughout his life. He stated that he had inherited it from his father who was also the person he had turned to when confronted with difficult decisions. John related in the interview that he phoned his father, advised him of his testicular cancer and the surgeon's recommendation, and asked for advice. His father responded with something like: "Son, first it was your legs, now it's your balls, next you'll be telling me you're only left with your head! Well, from now on I'm only getting you hats for Christmas!" John immediately knew what to do, phoned the surgeon, and told him to remove both testicles.

Therapists' self-disclosure.

Though some of the more serious schools of psychotherapy have portrayed therapist self-disclosure as inappropriate, most counsellors and psychotherapists do see it as appropriate if used with clients sparingly and only when clearly relevant to the client's process at the time, essentially either to build or strengthen rapport or as a way of demonstrating a point, such as "there are ways to deal with this kind of problem: this was how I approached it…". From the perspective of therapeutic absurdity, self-disclosure presents other potential benefits as well as rapport and guidance.

To be absurd in self-disclosure, therapists have to be willing to appreciate their own absurdity, make fun of themselves and what they do, including their work as therapists, and be able to let their clients make fun of them and what they do. They may also have to be prepared to tell untruths to clients by appearing to be self-disclosing an actual experience when in reality the story is a made-up metaphor for the client's situation that might have more impact if presented as an actual event.

Mindess (2001) urges therapists to display a humorous attitude about themselves and thereby role-modelling to the client:

….. modesty, lightheartedness, and an awareness that even the relationships and enterprises we are seriously engaged in are, in the long run, only parts of the human comedy (p. 5).

In describing how he shows humour in self-disclosure, Mindess points out that he does so spontaneously, not as a planned technique.

I merely allow myself to talk as I would with a friend, and since it is my natural inclination to make fun of myself, others, and life in general, that element creeps into my professional consultations as well. …… Because my clients know me primarily as a psychologist and consult me in that capacity, I make fun of psychology too (p. 7).

The formal strategy of self-disclosure restricted to minimal usage and content-appropriateness is reasonable. The unplanned, unstructured mocking of oneself and one's profession by the professional in a formal setting, in front of the person seeking assistance from that professional, is absurd.

THERAPEUTIC BENEFITS OF ABSURDITY.

As I have already made several references to potential benefits of absurdity for individuals, I will be brief in my comments here. Benefits can be loosely grouped into health benefits, interpersonal effects, effects on cognition and on how to approach problems and life in general.

Health benefits

There is now general acknowledgement that laughter can have beneficial effects on physical, as well as psychological, health, even though research results are inconclusive (Martin, 2001). The idea has a long history. For example Lefcourt and Martin (1986) refer to compilations of statements by philosophers and physicians since the 13th century, including this one by 19th century German professor Gottlieb Hufeland.

> Laughter is one of the most important helps to digestion with which we are acquainted; the custom in vogue among our ancestors, of exciting it by jesters and buffoons, was founded on true medical principles. Cheerful and joyous companions are invaluable at meals. Obtain such, if possible, for the nourishment received amid mirth and jollity is productive of light and healthy blood (cited in Lefcourt & Martin, 1986, p.2).

Interest and research in the idea increased significantly after the publication in 1979 of Norman Cousins book, *Anatomy of an Illness as Perceived by the Patient*, in which he described his recovery from the progressive degenerative spinal disease ankylosing spondylitis after a self-treatment program based on massive doses of comedy and vitamins. The focus of research and treatment has been mostly on immune system enhancement, pain management, cardiovascular and pulmonary improvement, and promotion of positive mood and expectations regarding recovery from illness.

Interpersonal effects

Non-aggressive humour tends to have a joining effect in social relations, releasing tension and pointing to a shared sense of the absurd. Humour and paradox can be seen as having therapeutic value when respectful of clients but 'disrespectful' of their problems and mechanisms by which the problems are maintained. Absurdity also inspires multiple levels of communication such as in irony, punning, word-play, incongruous juxtaposition, and paradoxes.

Cognitive effects

Absurdity can bypass or derail habitual cognitive structuring and stimulate new perspectives for people stuck in self-reinforcing thinking and behaviours. Many examples of this have already been provided, such as Farrelly's *Weird Left Tit Interview*.

Approach to problem resolution and to life in general

Absurdity can provoke more creative ways of looking at and approaching difficulties. Related to this, absurdity implies multiple realities, loosening a person's "grip on reality" which, though appearing an unreasonable thing to do, can be very useful for people with dysfunctional personal realities. It can also promote some detachment from problems or, at least, a shift in how a person relates to problems, as well as more flexibility and hopefully a more humorous or playful approach to life. By holding up the comic in face of the tragic, humour can provide hope against a backdrop of pain and hopelessness.

In therapy absurdity grabs attention and tends to be energising, vivid and memorable. Clients tend to be active participants in therapy involving absurdity, both within and outside actual sessions. Therapists' playfulness, spontaneity and non-aggressive humour can provide positive modelling for clients which also means that therapists working with humour should be able to respond positively when they are the butt of the joke.

Though unlikely to be to a profound degree, reason-based therapies can produce some of the benefits referred to here, such as interpersonal affinity, problem-solving skills, new insights or ways to consider things, and positive attitudes. My argument is that the degree to which these are achievable is limited when only reason is used. For example, absurdity stimulates greater emotional response and release, more dramatic shifts of perspective and more enthusiastic participation. Moreover, some of the effects of absurdity mentioned above, such as playfulness and spontaneity, and laughing at the comic in the midst of the tragic are unlikely to arise in response to reason other than as paradoxical or humorous responses, in other words as absurdity.

Both reason and absurdity can lead to change. The question is whether they lead to different levels or types of change, such as modification, first-order or second-order change, metamorphosis or transcendence, and whether the change is one of adaptation or liberation. Are the therapist behaviours and interventions described in this chapter potential means to bring about profound change and clients' liberation from their habitual self-destructive patterns and oppression of others in their lives? I have discussed the limitations of reason as a means of knowledge and a change process and have suggested that absurdity is a potential means to profound change and liberation. I will aim to bring these points to a conclusion in the final chapter.

CHAPTER 7: CONCLUSION

THE DOMINANCE, LIMITATION AND PARADOXES OF REASON

This thesis has focused on reason and absurdity as means to understanding the world and means to facilitating change. I have also pointed to some ethical and philosophical implications, particularly those of power and control, and concepts of normality and sanity. Reason is the dominant influence shaping the practice of science and the controlling orthodoxy across many professional and academic disciplines, including psychiatry and psychology, and stemming from these psychotherapy. An important question raised is whether reason and absurdity can co-exist as means to 'knowledge' and change or, being antithetical, are mutually exclusive.

In these concluding remarks I would like to continue with the personification of reason and absurdity as a literary device, keeping in mind, as referred to in Chapter 1, the risk that reification and personification can be used to pit the two processes against each other as antagonistic forces. This is precisely my reason for personifying here because the irony of the question above is that from the perspective of reason the answer must be the latter. Absurdity can co-exist with reason and, for that matter, with any number of models of reality and prescriptions for action but reason must reject any process, such as absurdity, not conforming to its prescriptions. Also reason presupposes itself to be the superior of the two and to be the solely valid means to knowledge. Consequently reason must hold onto its dominance. The limitation of relying on one dominant mode of understanding the world, and the risks inherent in leaving reason to its own devices, have already been pointed out. I have been arguing that reason is limited as a means to knowledge, action and change. I have also claimed that reason has usurped all other approaches to understanding the world, to be established as the only legitimate means to knowledge and thereby becoming a form of persuasion, power and control. In so doing, alternatives such as absurdity are portrayed as pejorative, insane or dangerous. This state of affairs locks reason into a triadic paradox.

The paradox of reason; part 1 - reason's delusion of grandeur makes it absurd

Reason is limited both as a mode of understanding and as a means to change. It can be useful when dealing with simple phenomena or linear processes but insufficient, at times inappropriate, when dealing with complex phenomena or nonlinear processes. For example, it deals with complex phenomena by breaking them down into simple components and projecting upon them mechanistic relationships. Unfortunately reason, as in the proponents of reason, is mostly oblivious to its limitations, believing that it can be used in all cases and is the only legitimate means in all cases. This is akin to the psychiatric diagnostic criterion of 'delusions of grandeur'. The paradox is that in the belief that reason can lead to omniscience, the capacity to see its limitations is lost. In Chapter 2 it was revealed that part of the definition of reason is that it is a form of persuasion, a convincing force to establish superiority through power. The belief underlying reason is not only one of omniscience but also omnipotence.

Also discussed in Chapter 2 was that reason becomes dangerous when left to its own devices to deal with situations it is incapable of dealing with, often leading to unreasonable and sometimes destructive outcomes ranging from individual suffering to global destruction. Operating from its grandiose delusional base it becomes self-justifying and self-perpetuating. It needs the modifying influence of alternative ways of being and understanding, the most dramatic of which is absurdity as it is the antithesis to reason.

The paradox of reason; part 2 - reason needs absurdity to be reasonable

Reason needs absurdity as a defence against delusional grandiosity. Ironically, the danger inherent in reason is that it leads to aloofness and disconnection from the world. It needs the counterbalances of not being taken too seriously, having its foibles and limitations laughed at, and rediscovering, rather than fearing, spontaneity, playfulness and enchantment.

Ironically, reason also needs absurdity to stop it from leading to unreasonable or absurd outcomes. From a perspective of absurdity (of which there may be many), reason's fundamental flaw is its insistence on a commonality underlying all phenomena, along with its insistence that

such commonality can be discovered and explained through methodical application of reason, mostly through science. The belief in commonality governed by discoverable laws is a theoretical or philosophical position, not knowledge of facts. Absurdity and the 'alternative paradigm' throw up the possibility of many illogical, ever-shifting, undiscoverable 'realities' that may be directly experienced. This contrasts with the reason-science paradigm in which knowledge is sought via a second-hand process of analysing data believed to represent a single reality consisting of bits interacting according to underlying principles or sets of laws. The bits are reconstructed into theoretical wholes by following a sequential process in which each step must be consistent with the previous. The limitation of reason is that is unable to detect when a premise is faulty and so logically progresses along a path to faulty outcomes, some of which can have disastrous consequences.

Perhaps the paradox of reason is also relevant to absurdity in that they may both need each other to avoid disastrous outcomes. I am unequivocally stating that reason needs absurdity to avoid becoming a force of delusion and destruction. In Chapter 2, I also referred to the possibility that perpetual absurdity might lead to madness, not as defined by reason but in an existential sense of being stranded without meaning or structure. Reason and science are useful tools to create a world of things humankind can manoeuvre through and manipulate. Absurdity stimulates an energy and enthusiasm taking humankind beyond the mundane, exposing bigger visions of the world we are manipulating, and dissolving the boundaries and barriers between things and between people.

The paradox of reason; part 3 - reason has to become absurd to be reasonable

This third part is the crux of the whole paradox. Though a counterbalance for reason, absurdity can never be accepted by reason while it is seen as a threat. Absurdity contradicts the presuppositions on which reason is based. Reason has to be allowed to go beyond the antithesis to co-exist with absurdity, but that would be an unreasonable thing to do; it would be an act of absurdity. Consequently, reason can only be used the way it always has been, which is to ignore, minimise, colonise, vilify or nullify absurdity. While damning absurdity, reason itself is damned by the belief that it is the sole path to 'real' knowledge (grandiose delusion of omniscience) and

the belief that it is the overriding principle determining validity and normality (grandiose delusion of omnipotence).

Reason has ultimate authority as the sole means to knowledge. It demands control. It follows a single, predetermined path to understand a single, reasonable reality. It is a prescribed methodology that must be conducted correctly according to set rules. It is the realm of the expert. Absurdity is multitudinous and unpredictable. It is also ubiquitous, there for everyone, an expression of individuality. It is a threat to authority through its mocking and refusal to take things seriously. To accept any legitimacy of absurdity, reason would have to be divested of its authority.

ABSURDITY AS LIBERATION

Do reason and absurdity lead to different levels or types of change? Does reason mostly only bring about adaptation and modification and is it unable, on its own, to lead to profound change and liberation? Can liberation only arise from absurdity though perhaps sometimes in conjunction with reason? Hypothesis #1 presents reason as limited in the change it can bring about and absurdity as the means to stimulate profound change. The term 'liberation' implies profound change, not superficial change or adaptation. It may be that reason can be part of a process leading to profound change and liberation but hypothesis #1 states that it is most unlikely to, or may be unable to, do this on its own.

The concept of liberation is mostly used in reference to freedom from authority and power wielded by others, usually physical, social and political liberation through overthrowing a governing body. It does, however, have as much relevance to interpersonal relations and to intrapersonal psychological processes. Power, control and authority are usually maintained through reason. Rationales are provided for why things are as they are and why they must remain so. Forceful and persuasive arguments are used to create fear of alternatives and of change. These can be the rationalisations and persuasive arguments of an authoritarian governing body, an authoritarian person, or the authoritarian part of an individual's personality. To fight against reasoned argument and control with more reasoned argument and

control requires the acquisition of more power. Thus the fight goes on, becoming increasingly destructive, whether as bloody wars and revolutions, spiralling arguments, or psychological conflict and anguish.

The liberation of absurdity can take various forms, and be liberation from a range of constraints, but it is essentially liberation from personal realities represented and perpetuated through habitual behaviours, cognitions, attitudes, beliefs, sociocultural norms and social institutions arising from faulty or excessive applications of reason. Unlike reason, absurdity involves a refusal to play the game according to the rules (that have been set by reason anyway). It is illogical, unpredictable, outrageous, insane, impossible to pin down, bouncing back reflections as an 'Alice through the looking glass' topsy-turvy world of bizarre imagery. Reason, and authority, are rendered helpless in its presence.

This is the spirit of the following statement by the Nobel Prize winning Italian playwright, Dario Fo, from his book *The Tricks of the Trade*:

…… first, authorities, any authorities, fear above all other things laughter, derision or even the smile, because laughter denotes a critical awareness; it signifies imagination, intelligence and a rejection of all fanaticism. In the scale of human evolution, we have first *Homo faber*, then *Homo sapiens*, and finally *Homo ridens*, and this last is always the most difficult to subdue or make conform. Second observation: in their self-expression, always and invariably, ordinary people cannot resist, even in their representations of the most tragic of tales, finding a place for humour, sarcasm and comical paradox (Fo, 1971, p. 109).

Professor Terry Tafoya, a Native American academic psychologist and psychotherapist, depicts the power of absurdity as personal liberation in his description of the role the 'Chiffoneti', "a fascinating blend of priest, healer and trickster" in his culture of the Taos Pueblo Indians.

We respect the Chiffoneti with a feeling of mild fear mixed in with that respect for the Chiffoneti are predictable in their unpredictability. …. To be a master of something one must understand its polarities …. one must know order to recognise chaos and know chaos to recognise order. The Chiffoneti make us laugh at the serious things of life we would never have the nerve to laugh at publically …. the important people, the Sacred, and ourselves. In so doing the Chiffoneti plays with limits, juggles different levels of reality as though they were balls to allow irony to become visible (Wippich & Derra-Wippich, 1989, pp. 6-7).

After describing some of the Chiffoneti's actions, Tafoya concludes:

> The Chiffoneti are therefore very dangerous people because their laughter is the one weapon no bureaucracy, no dictator, no illness can defend against, and that is why the Chiffoneti of the American Indian peoples were locked away on reservations by the American federal government. But the Chiffoneti just keep laughing, and teaching the laughter to others (Wippich & Derra-Wippich, 1989, p. 8).

ABSURD THERAPY AS LIBERATION

The difficulty in using psychotherapy as the case study for this debate is that in most cases where absurd interventions occur in therapy sessions, therapists do actually have some rationale for them. Even when simply being playful with clients, therapists are usually being so for a reason. This can be related back to my earlier comments about reason masquerading as absurdity. They might be playing to help the client relax, or to build rapport, or to assist the client in laughing at the problem, or to help the client develop a more playful attitude towards life in general. Nevertheless, many therapists I have talked with who work with absurdity describe it as the most potent factor in stimulating the more significant changes they make. Another frequent comment is that, even though they can usually see the reasons why they are introducing absurdity into the session, it is when they have done so spontaneously, as a leap of faith, that the more dramatic shifts seem to occur for the client. Perhaps the absurdity comes first, has its impact, and then reasons for this are thought up. If the change is positive, the reasons, if there really are any, probably do not matter anyhow.

Psychological liberation involves profound changes in how individuals perceive and respond to their environments. There is a connection between these, however, as they are all about liberation from the influences of undesirable or destructive power. This is as much to do with how people try to have power and control over their lives, and themselves, often in unreasonable and destructive ways, as it is to do with having power over another person. Psychological liberation can be from the power of physical illness, habitual self-defeating

cognitive and behavioural patterns, or of abuse by others. Liberation of this kind can only come from within the person and involves a profound breaking free from old ways of being and old reasons for being the way the person was. It is difficult to see how psychological liberation can arise out of a relationship, such as therapist and client, based on power inequity and the attempt (even when implicit) to persuade or impose change. Similarly, profound change is unlikely to be achieved from a reliance on solving "problems by using the same kind of thinking we used when we created them" (to use Einstein's quote referred to earlier). If therapies based on reason lead to therapist-client relationships based on persuasion, power and control, as presented in hypothesis #2, they can hardly lead to liberation from power. It follows that ultimately therapists must throw aside power, control, and also reason to allow clients' liberation to arise from within themselves. It also follows that only by liberating themselves from the tyranny of reason (and grimness) can they help clients liberate themselves from the tyranny of power.

Letting go of power, control and authority is difficult. They represent security, status, respect, and acceptance into the mainstream of one's profession. Perhaps the need to protect the status of therapist as professional, expert or authority has been one of the driving forces behind the profession's tendency to ignore, demean, or be hostile towards the therapeutic role of absurdity. To learn how to be absurd therapeutically, therapists have to unlearn their dependency on reason and control. It becomes a process of rediscovering enchantment and spontaneity, engaging with the comic, developing an appreciation of paradox and irony and translating these into how to respond to problems. Absurd therapy as liberation is as much to do with liberation of therapists as it is with liberation of clients.

APPENDIX: PILOT INTERVIEWS FOR EARLIER THESIS

The practicing psychotherapists selected for the semi-structured interview were professionals with substantial experience with whom I had been acquainted professionally for some years. The interview structure had been devised as a pilot with the intention to develop a final structure for interviews with several well-known therapists in Australia, USA and Europe known for their use of a nonrational, paradoxical or humorous approach to therapy. I used the interviews to gain ideas, not to test my hypotheses, and not as a survey of practitioners.

I also interviewed the national director of a major Australian environmentalist organization as at this stage the intention was still to look at absurdity as a change process both as personal change through therapy and as social change through green political activism. It was hoped that some green politicians and activists who use unconventional and dramatic actions would also be identified a potential interesting interviewees.

The interviewees had all been advised of the topic previous to the interview and I commenced the interview by providing background information on my PhD topic and reasons for conducting the interviews. I offered basic definitions of reason and absurdity and described a couple of examples of rational and nonrational or possibly absurd actions in their relevant field. There then followed a preliminary discussion about their approach to therapy (or, in the case of the environmentalist, his approach to activism) and what they do that is based on reason and what might be examples of absurdity.

Therapist Interview

Question 1
What do you see as the advantages & disadvantages of the two approaches?

Question 2
What leads you to using each approach? What kinds of change do you think are achieved/achievable through each approach?

(Some discussion of this question included whether each approach led to different kinds of change, such as cognitive-behavioural, experiential, normative, and levels of change, such as progressive/systematic/gradual as opposed to sudden/rapid/unpredictable, and conservative or radical change?).

Question 3

How do you assess change in your client, for example do you think it should be quantifiable, observable etc? How do you assess whether your approach is working, needs modifying or changing etc? How do you know what you (think you) are doing?

Question 4

Are there ways you combine the two approaches, such as trying to get across 'rational' information during or after an absurd intervention?

Question 5

How do you see your role and self in using each approach? Do they differ, such as scientist/educator/expert or artist/'fool'/co-discoverer?

(Some discussion of this question included the importance to therapy of science, intellect, reason, logic, techniques and technology or art, play, creativity imagination, intuition, spontaneity etc.).

Question 6

In what ways do you think these different approaches to change might reflect and/or create different types of relationship, such as in the power dynamics/structures/behaviours and each person's experience of power? How do you deal with power in the therapist-client relationship?

Question 7

What philosophical issues do you think may be represented or implied by each approach? How does your dual role affect your philosophical position? Which philosophical models are you

most influenced by in your work and which therapeutic models, style and techniques are you most influenced by and prefer to use?

Environmentalist

Question 1
What do you see as the advantages & disadvantages of the two approaches?

Question 2
What leads you to using each approach? What kinds of change do you think is achieved/achievable through each approach?

(Some discussion of this question included whether each approach led to different levels of change, such as conservative or radical change, green conservatism or activism, evolutionary/systematic/gradual or revolutionary/rapid).

Question 3
How do you ascertain how effective you have been? How do you assess whether your approach is working, needs modifying or changing etc? How do you know what you (think you) are doing?

Question 4
Are there ways you combine the two approaches, such as trying to get across 'reasonable' information during or after an 'unreasonable' direct action?

Question 5
How do you see your role and most effective way to conduct the debate, such as with your use of science and reasoned argument, quantitative measures, established structures and procedures, respectability or direct action, imaginative stunts, provocative and 'unreasonable' interventions, sabotage, qualitative arguments, passion, intrinsic value, ecocentricity etc.?

Question 6

In what ways do you think these different approaches to change might reflect and/or create different types of relationship, such as in the power dynamics/structures/behaviours and each person's or group's experience of, and access to power.

(Some discussion of attitudes to, and personal use of, power and whether or how change can be imposed from above, such as by government and within his own organisation or come from the grassroots. Also discussion about what decision-making processes the environment movement and his organisation should use).

Question 7

What philosophical issues do you think may be represented or implied by each approach? Which philosophical and political models are you most influenced by in your work?

Some Typical Responses to the Questions

Therapists

Question 1

<u>Advantages of reason:</u>

- Appropriate framework as a starting point, especially in training & teaching.
- Common model/communication with professional peers - immediately establishes a context for discourse.
- Provides respectability and for a trained professional produces respect.
- Some problems need to be worked through methodically.
- Some clients are so unreasonable they need to learn how to reason.

<u>Disadvantages of reason:</u>

- Restricts flexibility - which therapist needs to have.
- Can get stuck in your model - which frequently happens.

- Impedes an authentic meeting with the other.
- Sessions can become predictable and boring.

Advantages of absurdity:

- Frees you to be yourself.
- Human to human encounter – natural, real, genuine. Therapist and client join.
- More likely to be creative.
- Laughter and surprise can be liberating.
- Therapy more likely to be interesting and engaging.

Disadvantages of absurdity:

- You can lose your grip completely and be the last to know. You might think you are being therapeutic but might actually be lost in your own wackiness.
- Produces a greater potential for upsetting people.
- What you are doing can be trivialised as not serious therapy.
- You might become ostracised by more conservative peers.

Question 2

- Reason and thinking tend to lead to superficial change. You must connect with emotion. Emotional involvement in the process is more likely to lead to lasting and significant change.
- Follow through and consolidation may be better if systematic. So absurdity brings about significant change that can then be consolidated through reason.
- Reason more likely to induce therapist to see self as the 'doer' - this is a common trap. Significant change needs to emerge from clients. They need to see the change coming from them, not coming from the therapist.
- Reason can be pushy. People won't change if they are pushed.
- Most change is incremental, minimal, gradual though there are moments when change occurs significantly and the whole system readjusts.

Question 3

- Feedback from client tends to be more vivid and real with absurdity.
- Rational therapists are often less concerned about feedback, preferring other observable criteria.
- Keep track of clients' nonverbal and verbal responses.

Question 4

- Absurdity gets attention.
- Absurdity can break the ice when things are getting too grim, boring, or repetitive.
- Absurdity lets you speak to clients in their own language - at the point of their own pain.
- You can consolidate with reason.

Question 5

- Absurdity is more to do with who you are than what you do.
- Absurdity is there anyway - you have to overcome it to be 'clean' (reasonable).
- It is more important for clients to feel understood than be given explanations to understand.
- Reason tends to be more formal and restrictive whereas absurdity allows you to use more of yourself in the session. There is more energy with absurdity.

Question 6

- Being absurd uses but also generates a lot of personal power and power in the relationship.
- Boundaries define the power. Absurdity is a good way to dissolve boundaries.
- Therapists are usually in a one-up mode, implicitly or explicitly, though hopefully this is a benign one-up designed to help the client.
- The more therapists see themselves as experts, the more powerful they will see themselves.

Question 7

- You can't have the two belief systems simultaneously.
- A number of the therapists identified having reason and linear processing mainly in their professional life but seeing their personal life as mostly absurd.

- The spiritual aspect is the highest level but both approaches can be equally compatible with spirituality (stated by a Christian).
- Absurdity is the language of the mystical and profound (stated by a Buddhist).
- Main influences from models of therapy were reported as Jungian, Gestalt, Ericksonian, Provocative Therapy, Psychodrama, Art Therapy, R.E.T., C.B.T., Systemic/Strategic approaches to Family Therapy, Brief Strategic Therapy, and Narrative Therapy.

Environmentalist

Question 1

Advantages of reason:

- The common model and basis of communication that immediately establishes a context for discourse. Once this has been established I can drop the model.

Disadvantages of reason:

- Creates a particular 'reality' which we can get stuck in.
- Our reason has produced most of our environmental problems.

Advantages of absurdity:

- Can have fun and play.
- We must be able to laugh at ourselves.
- Need to be intuitive and tuned in to use absurdity & humour appropriately and effectively

Disadvantages of absurdity:

- You can lose your audience if ill-timed.
- There are times when you have to do it their way to be included.

Question 2

- Need to aim for profound change, including changing our concept of self to an ecological consciousness beyond human-centredness.

- Change occurs mostly gradually, small steps at a time and not always forward. The rare occasions of sudden and dramatic change are exciting. He pointed out that he is aiming for significant change, especially in the long term.
- Some things you are not allowed to joke about.
- Timing must be appropriate - "If they think they are going to be laughed at you can lose them".

Question 3

- Feedback from peoples' nonverbal behaviour and atmosphere in the meeting.
- Absurdity can lighten up a meeting.
- You do not necessarily know in short term - long term effects might be quite different and not able to be anticipated. Reason is safer.
- He judged his constituency (membership) to be the most important gauge.

Question 4

- Get their confidence and acceptance with reasonableness and then be absurd ("cathartic, lightning rod").
- Good crazy memorable one-liners.
- You can plan actions using both approaches together. Planned but still allowing fun, play and some spontaneity while aimed at having an effect.
- He has activists dressed up as crazy while he talks to media reasonably and wearing a suit.
- Absurdity can be empowering for activists and stimulating to think up ideas.

Question 5

- As a medium of change, not sure if either is more or less useful.
- Different ways of putting a question - varies according to context and will influence the kinds of responses you get (he gave the example: should big people hit little people?).
- More to do with your lightness and your openness rather than the actual methods you use, for example approaching politicians in meetings on a human basis, dropping the prescribed

roles, meeting as people not roles. Absurdity is more likely to arise naturally in a meeting of people than in a meeting of roles.

Question 6

- He has different power relationships to deal with, such as with activists, with the public, and with decision makers. He sees his position as a powerful one that he needs use respectfully.
- He sees himself as surrounded by abuses of power. He sees as a challenge the need for him to work with power non-violently and ethically without being seen as weak.

Question 7

- Seeing less difference between the two approaches though saw absurdity as a way to work with chaos.
- Sees himself as planting seeds in lots of places, often not knowing what would develop from them but creating movement and unsettling otherwise entrenched structures.
- Meditating as preparation for a meeting.
- Main influences are deep ecology, Buddhism and chaos theory, which he sees as being the fuel for his ability to play with absurdity in such serious contexts.

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